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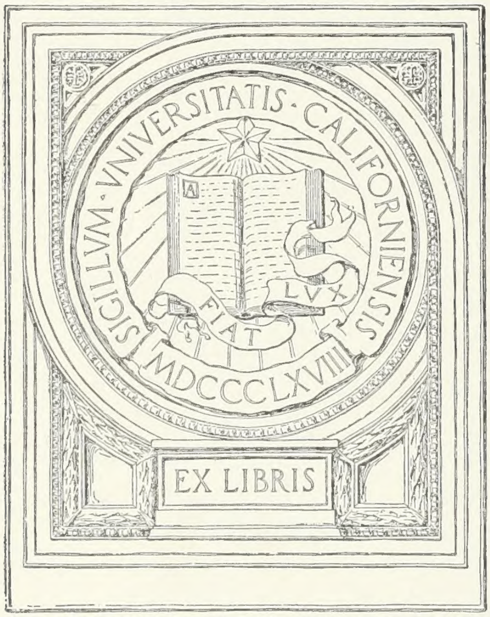
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MICHIGAN MEDICINE

the journal of the
michigan state
medical society

July 1965 • Vol. 64 • No. 7

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And . . . More News about Gala MSMS Centennial

MEDICINE AND VOLUNTARY HEALTH DAY

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Sept. 19—Medicine and Religion Day

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Sept. 21—Medicine and Medical Organization Day

Sept. 22—Medicine and Science Day

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Sept. 24—Medicine and Government Day

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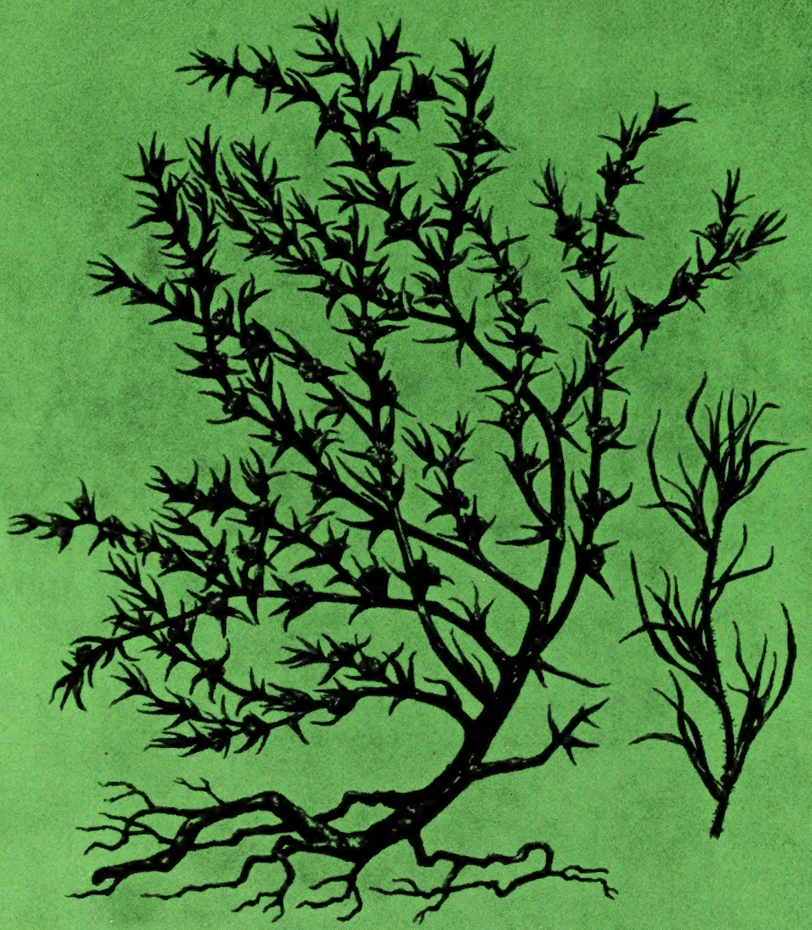

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MICHIGAN MEDICINE

the journal of the michigan state medical society

July 1965 • Vol. 64 • No. 7

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the president's message . . .

Hats Off to Our Gals!

The other day, a colleague asked me at the hospital, "What have you found in your visits around the state this year?"

I could have told him about the keen interest amoung young doctors in the socio-economic concerns of medicine.

Or I could have described some of the excellent public-service projects carried on by county medical societies.

Or I could have reported on the growing interest I have found in postgraduate education . . . or legislative understanding . . . or . . .

But I chose to reply to him.

> "Doctor, I want you to know that we are blessed in Michigan with active and dedicated organizations of Women's Auxiliaries and Medical Assistants."

I am convinced this is true. And I know that we should show our appreciation more often.

* * *

WE HAVE MANY problems in the medical field that need the combined efforts of the doctor . . . his wife . . . and his medical assistant.

The state Woman's Auxiliary and the Michigan State Medical Assistants Society perform many, many jobs with distinction as they seek ways to help us.

Both organizations are doing yoeman work in the legislative area. Both are active in career recruitment. Both conduct programs for their own individual growth. Both carry out community service projects far too numerous to mention.

* * *

NOW, LET US direct a comment or two to my fellow MSMS members. Have you personally encouraged your medical assistant to be active in the MSMAS? And have you suggested that your wife take part in the work of the Auxiliary? These organizations merit your support—it is important to MSMS that they be strong organizations.

And perchance the Doctors will show this message to their wives or medical assistants—so I have the opportunity here to challenge them to do even more to enhance the total medical profession. The Gals can work on this every day at the club, grocery store, church, PTA, etc.

Medicine is the life and livelihood of all three of us . . . the doctor . . . his wife . . . and his medical assistant.

Let's all continue to make it even a stronger working team here in Michigan. Thank you.

Oliver B. McGillicuddy, M.D.

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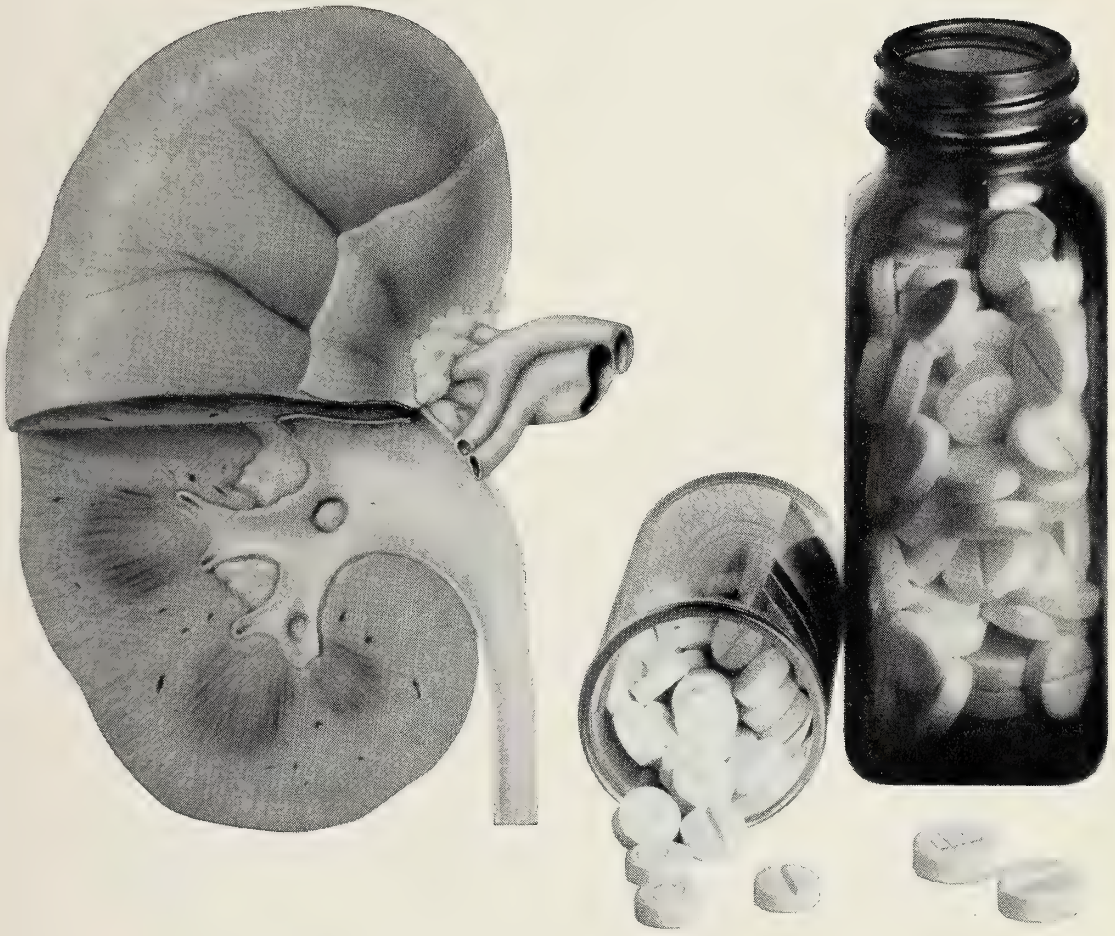

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For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

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2. Submit original, double-spaced typewritten copy and one carbon copy on letter size (8½ x 11 inch) paper.
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5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by the Journal. The Journal will pay the first $25 of the engraving bill, and the author shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.
6. References will ordinarily be limited to seven in number. Exceptions may occassionally be made.
7. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.
8. Articles should ordinarily be less than four printed pages in length (3000 words).
9. References should conform to *Cumulative Index Medicus*, including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.
10. Specify address to which galley proof should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.
11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.
12. It is understood that material is submitted for exclusive publication in MICHIGAN MEDICINE.

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References: 1. Carpenter, E. B., South. M.J. 51:627, 1958. 2. Crookshank, J. W.: J. Louisiana State Med. Soc. 114:272, 1962. 3. Feinberg, I., et al.: Am. J. Orthoped. 4:280, 1962. 4. Fitzgerald, W. J.: Miss. Valley M.J. 82:146, 1960. 5. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 6. Meyers, G. B., and Urbach, J. R.: Penna. M.J. 64:876, 1961. 7. Truitt, E. B., Jr., Morgan, A. M., and Nachman, H. M.: South. M.J. 54:318, 1961. 8. Weiss, M., and Weiss, S.: J. Am. Osteopath. Assn. 62:142, 1962.

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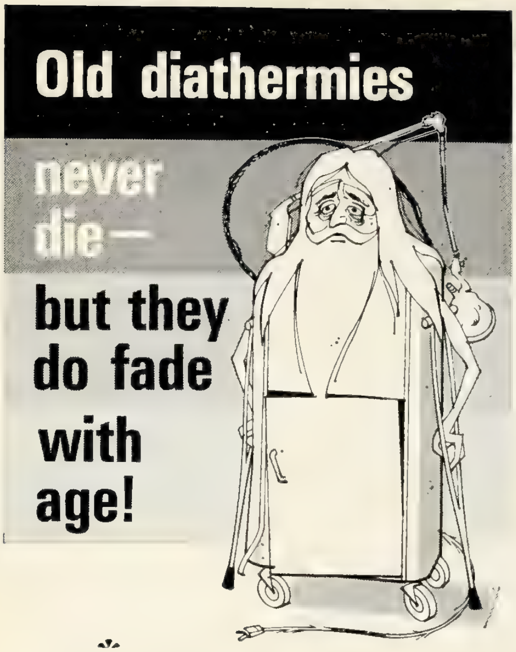

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NEWS BRIEFS

Hermann Pinkus, M.D., Monroe, has been selected as the recipient of the Herxheimer Medal, given biennially by the German Dermatological Society to a distinguished dermatologist. The presentation will be made at the annual meeting of the German Dermatological Society, September 29-October 2 in Freiburg, Germany. Doctor Pinkus is an honorary member of the society.

Allison B. Henderson, M.D., Detroit, presented a paper on "Hyperproteinemia, Anemia and Blood Sludging" at the Stockholm meeting of the tenth Congress of the International Society of Haematology.

Edmond L. Cooper, M.D., Royal Oak, has been re-elected secretary-treasurer of the American Orthoptic Council.

Two Nobel Prize winners, **Severo Ochoa**, M.D., 1959 laureate in medicine, and **Willard F. Libby, Ph.D.**, 1960 laureate in chemistry, made major addresses at the dedication June 3-5 of the new $5.2 million biochemistry building and $6.6 million chemistry building at Michigan State University.

The Saint Johns Hospital Men's Guild selected **Clarence L. Candler, M.D.**, Detroit, as its "Man of the Year." He especially was cited for service on the hospital staff since its opening in 1952 until his recent retirement.

Two University of Michigan Medical School professors, **Richard C. Schneider, M.D.**, and **Bartley E. Antine, M.D.**, writing about football helmets in the Journal of the American Medical Association, report that the single face bar furnished the best vision, but the least protection. By comparison, a new style helmet with external padding and a firm plastic attachment at cheek level afforded excellent protection, but the poorest vision. The Michigan doctors comment that obstruction in the lower quadrants of the visual field can be a threat to safety that might override the physical protection of the helmet itself.

George H. Agate, M.D., director, Division of Epidemiology, Michigan Department of Health, is the new president-elect of the Conference of State and Territorial Epidemiologists. He was chosen at the recent biennial conference held in New Orleans.

Say you saw it in Michigan Medicine

Two MSMS members have been appointed by Governor Romney to the new State Mental Health Facilities Advisory Council to help plan use of federal funds for construction of community mental health centers and retardation facilities. Named were **Edward H. Rodda, M.D.**, Bay City, and MSMS Councilor, who will represent the Michigan Association of Emotionally Disturbed Children, and **Oscar Stryker, M.D.**, Mt. Clemens, representing the Michigan Health Officers Association. The Council is comprised of seven state officials and five citizen members.

Leonard D. Schramm, formerly with Michigan Blue Shield, is now with the President's Committee on Equal Opportunity in Housing, under a Presidential assistant, putting this operation "on the White House staff." His office is quartered in the Executive Office Building, Room 216, Washington, D. C.

Recently the community of Chesaning held a special dinner to pay tribute to **Walter Buzzard, M.D.**, physician there for the past 33 years. A scroll of recognition and a gift were presented.

Edmond L. Cooper, M.D., Detroit, has been reelected secretary-treasurer of the American Orthoptic Council.

Walter M. House, M.D., has been advanced from professor to chairman of the department of radiology at The University of Michigan. He replaces **Fred J. Hodges, M.D.**, who is retiring after 31 years as chairman.

James C. Cook, M.D., Detroit, will be an official delegate to the Eleventh International College of Radiology at Rome in September.

Henry D. Kaine, M.D., Detroit, is now chief of the out-patient endocrine clinic at Harper Hospital, and also director of the Michigan Diabetes Detection Program.

A speaker at the Fourteenth Annual Conference of the Michigan Association for Retarded Children in Kalamazoo in June was **Donald E. Christensen, M.D.**, Gaylord.

Devere R. Boyd, M.D., was the recipient of the Muskegon B'nai B'rith Citizen of the Year citation, cited primarily for his efforts to locate a new state children's mental hospital in the Muskegon area.

E. Stephen Gudjian, M.D., chief of staff of Grace Hospital and chairman of the WSU neurosurgery department, has been proclaimed "The Outstanding Armenian of the Year" by the Detroit Armenian Cultural Association.

Donald Damstra, M.D., Brighton, discussed "Alcoholism, The Family Disease" at a public forum sponsored by the Muskegon County Council on Alcoholism. **Edward Heneveld, M.D.**, is chairman of the Council.

Doctor . . .
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Kenneth E. Gamm, M.D., Grand Rapids, was appointed by the AMA to serve as an official representative to the Fifth International Thyroid Conference at Rome.

Richard Komisaruk, M.D., director of the Wayne County Clinic for Child Study, was one of the speakers at a recent conference in Detroit to seek ways to combat child abuse.

The Arthur Hill High School in a special assembly program conferred an "Honor Alumnus" award this spring on **Robert F. Powers, M.D.**, community leader, past-president of the Saginaw County Medical Society and a graduate of Arthur Hill.

The guest speaker at the recent Tucson Chamber of Commerce Safety Luncheon was **John R. Rodger, M.D.**, Bellaire, chairman of the MSMS Committee on Highway Accident Prevention. He also talked to the Pima County Medical Society and appeared on TV.

Keats K. Vining, Jr., M.D., Grand Rapids, spoke at the "Institute on the Education of the Diabetic and his Family" presented by the School of Public Health at the University of Michigan.

The American Medical Association Education and Research Foundation's Committee on Tobacco and Health has authorized 15 new tobacco research grants, including one to **Sigmundur Gudbjarnson, Ph.D.**, Wayne State University School of Medicine, and to **Roy D. Hudson, Ph.D.**, University of Michigan Medical Center.

MEDISCENE

July 17-18—MSMAS Upper Peninsula Seminar, Northland Hotel, Marquette.

July 29-30—Coller - Penberthy - Thirlby Medical Conference, Park Place Motor Inn, Traverse City.

Sept. 16-19—American Medical Writers Association, Statler Hilton, Detroit.

Sept. 19-24—MSMS Centennial Session, Cobo Hall and Sheraton Cadillac Hotel, Detroit.

Sept. 21-24—Woman's Auxiliary to Michigan State Medical Society, Ponchartrain Hotel, Detroit.

Sept. 21-24—5th Annual Michigan "Doctors and Wives" Art Exhibit, Cobo Hall, Detroit.

Sept. 22-23—Michigan Medical Assistants Society Annual Meeting, Statler Hilton, Detroit.

Sept. 23—Michigan Health Council Annual Meeting, Cobo Hall, Detroit.

Nov. 3—Diabetes Day, Genesee County, Flint.

Nov. 4—Southwestern Michigan Clinic Day, Battle Creek Country Club.

Nov. 7-13—Community Health Week.

Dec. 2—Saginaw Academy of General Practice—Vascular Clinic Day, Bancroft Hotel, Saginaw.

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*Dorhout Mees, E.J., and Geyskes, G.G.: Acta med.scandinav. 175:703,1964.

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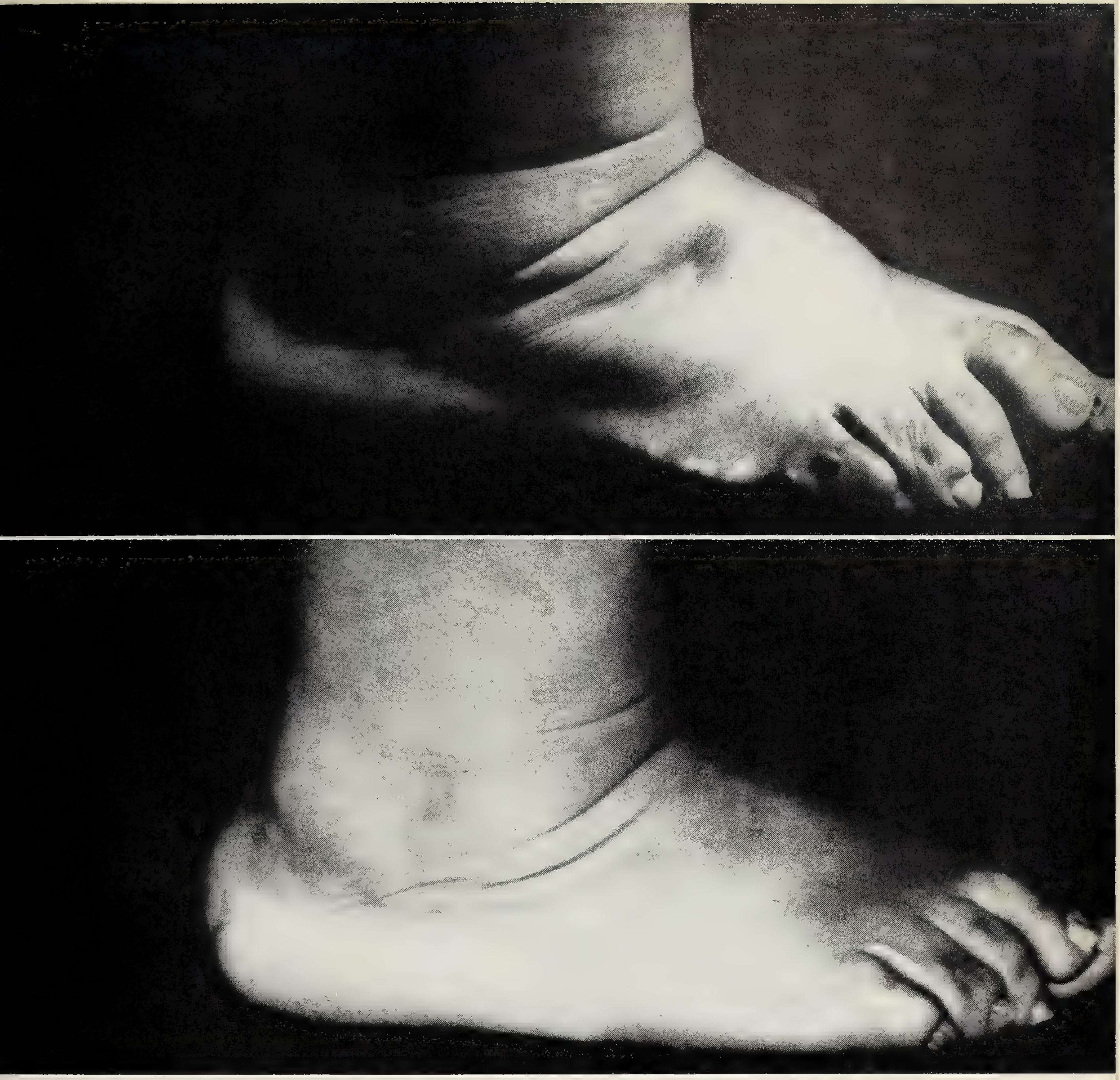

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SCIENTIFIC PAPERS

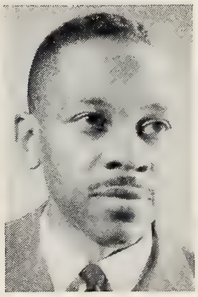
THE UNRELIABLE PROFESSIONAL BLOOD DONOR

By
George C. Hill, M.S., M.D.[a]
Sik Woo Ting, M.D.[b]
Ernest M. Berkas, Ph.D., M.D.[c]
Joel Shrager, M.D.[d]
Donald Lipsey, B.S.[e]

Introduction

Modern day surgical accomplishments are dependent on surgical technical knowledge, competent anesthesia and availability of ample quantities of whole blood obtained from willing donors.

Transmission via whole blood transfusion of the virus-causing homologous serum jaundice is said to develop in 0.2 per cent to 0.5 per cent of all patients receiving blood.[1] Despite many attempts to implement some method,[2,3,4,5] there is no simple effective screening method to reject as donors all asymptomatic carriers of homologous serum jaundice.



CO-AUTHOR
George C. Hill, M.S., M.D.

Blood collecting stations reject those who have had hepatitis, when this history is obtained from prospective donors. If a donor has had hepatitis in the past and does not elect to relay this information prior to blood donation there is no method yet devised to keep this blood off the market.[3]

* * *

THE RELIABILITY of the blood donor is a variable that determines, for the most part, the transfusion risk of donated blood.

The following case history is presented as an example of how an unreliable blood donor can injure himself as well as cause difficulty for the commercial blood bank and be a threat to blood recipients.

Case History

On February 21, 1963, a 48-year-old male was admitted to the Dearborn Veterans Administration Hospital complaining of epigastric pain, nausea and emesis of three weeks' duration. He also stated that melena, vertigo and asthenia had been present for the same period. The patient admitted to chronic alcoholism and was unemployed. He had been treated for peptic ulcer since May, 1945. In September, 1950, he was admitted to the hospital with jaundice and was treated for a severe case of well-documented infectious hepatitis. In October, 1953, he was admitted to another hospital where subtotal gastrectomy was performed because of duodenal ulceration with obstruction. From March, 1957, until February, 1963, he had been admitted to various hospitals at least 11 times with the diagnosis of anemia of undetermined origin.

During these admissions all studies failed to disclose the source of the blood loss.

On this admission the hemoglobin was 8 gms. X-ray study, gastroscopy and sigmoidoscopy, however, failed to disclose ulceration. No blood was found in the stool.

* * *

SHORTLY AFTER admission 2 units of blood

---

[a] Staff Surgeon, V.A. Hospital, Dearborn, Michigan.
[b] Chief, Anesthesiology, V.A. Hospital, Dearborn, Michigan; Associate Professor Anesthesiology, Wayne State University Medical School.
[c] Chief, Surgery Department, V.A. Hospital, Dearborn, Michigan; Associate Professor of Surgery, Wayne State University Medical School.
[d] Chief, Pathology Department, V.A. Hospital, Dearborn, Michigan; Associate Professor of Pathology, Wayne State University Medical School.
[e] Medical Student, Wayne State University Medical School.

TABLE I.

Total Patients	**41**	
No. of Deaths	**5**	**12.1%**
Total Units of Blood	**235**	
Average Units/Episode	**5.73**	

were given to treat the anemia thought initially to be due to stomal ulceration. The patient improved after one week and was given a weekend pass. After returning to the hospital, his hemoglobin was found to be lower than three days earlier.

A medical student, whose suspicions were aroused, intensively questioned the patient and found that the patient had, over the weekend, donated blood at a commercial blood bank. Further investigation in the Detroit area showed that, from 1955 until February, 1963, the patient had donated blood on at least nine different occasions to blood banks that were our blood sources.

Discussion

As a result of this information, we were stimulated to review the experience with homologous serum hepatitis at our hospital since July, 1955. During this period 41 cases of hepatitis related to blood transfusions have been documented. These patients received a total of 235 units of blood with an average of 5.73 units per transfusion episode.[6]

It is interesting that 12 cases of hepatitis occurred in patients undergoing treatment for tuberculosis, all of whom received blood during thoracotomy.

Five of the patients with post-tranfusion hepatitis expired. However, in only one patient was death due directly to serum hepatitis. Of the remaining four deaths, one patient was admitted with homologous serum jaundice, experienced hemorrhage from a gastric ulcer, and subsequently succumbed to the complications of surgery. Two of the patients who died were discharged after the diagnosis of hepatitis was made and returned because of another problem and expired. The final death occurred during the active jaundice episode, but demise was due directly to an advanced neoplasm with widespread metastasis.

TABLE II.

Year	Surgical Tbc Cases	Total Tbc SHJ	Total Cases SHJ	Units Whole Blood	Source of Blood
1964 1st 6 mos.	19	0	0	1400	F
1963 2nd 6 mos.	20	1	1	1697	E + F
1963 1st 6 mos.	20	0	5	1600	E
1962	43	3	10	4146	E
1961	68	4	7	4800	E
1960	57	3	12	4376	E
1959	64	1	1	4040	E + D
1958	45	0	2	4116	D
1957	62	0	2	4011	C
1956	83	0	0	4265	B
1955	39	0	1	——	A

Annual relationship of number of whole blood transfusions as related to total incidence of serum homologous jaundice (SHJ), Tbc surgery, and SHJ. The final column indicates the various blood banking sources of blood used for transfusion. Practically all blood from source E was from professional donors while blood from source F is from volunteer donors.

From July, 1959, to July, 1963, when blood was obtained from Detroit commercial blood banks, 210 operations were done for tuberculosis and 12 patients developed hepatitis for an incidence of 5.7 per cent. We believe the higher incidence of hepatitis after transfusion in tuberculous patients is related to a closer post-transfusion follow-up. Many of these patients are hospitalized during the entire incubation period while mild cases in the tuberculous patients were more likely to be diagnosed than mild hepatitis that follows transfusion and surgery for other causes.

* * *

SINCE JULY 1963 we have used blood from a blood bank that uses non-professional donors. During this period, there has been only a single detected case of homologous serum jaundice, although we have used over 2800 units of blood during this period.

Summary

The reliability of the blood donor is an important variable in determining the risk of hepatitis after transfusion. The reliability of an individual who donated blood for money was found to be questionable. The frequency of hepatitis after transfusion at our hospital was greater when blood was obtained from blood banks using professional donors rather than unpaid volunteers.

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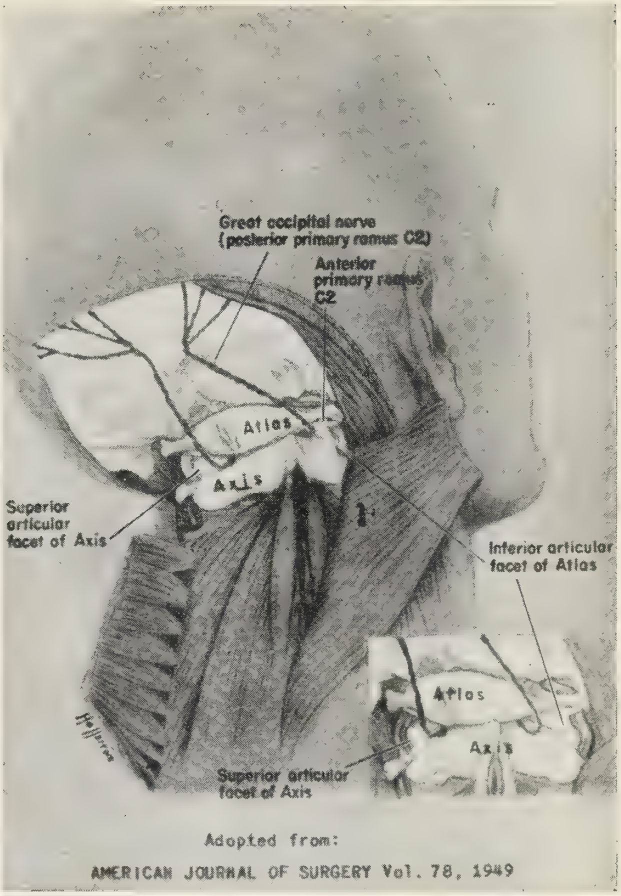
Syndrome Of the Greater Occipital Nerve

By
Seymour L. Osher, M.D.
J. Murray Day, M.D.
Both of Flint


Great occipital nerve (posterior primary ramus C2)
Anterior primary ramus C2
Atlas
Axis
Superior articular facet of Axis
Inferior articular facet of Atlas
Atlas
Axis
Superior articular facet of Axis
Hellerma

Adopted from:
AMERICAN JOURNAL OF SURGERY Vol. 78, 1949

Fig. 1. Cutaneous nerves of the posterior scalp and neck. Reprinted in modified form, from Anatomy of the Human Body, Lockhart, Hamilton and Fyfe, J. B. Lippincott Company, 1959, by permission of the publishers.

The role of the greater occipital nerve appears to have been insufficiently emphasized in the differential diagnosis of unilateral pain in the head. It is the purpose of this communication to

(1) focus attention on the variable pattern of pain originating from this nerve;

(2) insofar as possible, to isolate this variety of pain from the large group of headaches of generally similar nature; and

(3) to describe simple and effective clinical methods of diagnosis and treatment of this syndrome.

Anatomy

The greater occipital nerve (Fig. 1) is purely sensory, and derives its major origin from the posterior ramus of the second cervical nerve, with occasional contribution from the third cervical. It emerges through the superficial fascia at the superior nuchal line, about 3 cm. from the midline, and ramifies upward to the region of the vertex.

Its major communications on the scalp are with the lesser occipital and greater auricular nerves, which take origin from the anterior rami of the second and third cervical nerves, by way of the posterior cervical plexus. It will be noted, however, that pain originating from this nerve is not limited to its area of cutaneous innervation.

Clinical Features

In many instances this syndrome appears in connection with trauma of the skull or of the soft tissues of the posterior neck, most commonly following so-called "whiplash" injuries of the neck. It occurs not infrequently, however, in the absence of any history of injury. Several patients, in response to searching inquiry, have recalled apparently minor injury to the posterior neck many months or years previously, and coinciding closely with the onset of headache. When pain is atypical in nature and location, and no history of injury can be elicited, diagnosis is often not made for long periods of time.

* * *

IN OUR EXPERIENCE, many patients with such pain of great duration have received treatment for the diagnosis of atypical migraine, tension headache, psychogenic headache and histaminic cephalalgia. When symptoms appear and persist following trauma, treatment has often been rendered for long periods for the diagnosis of "post-concussion headache." Severe head pain of shorter duration following trauma has led on several occasions to a provisional diagnosis of chronic subdural hematoma, and these patients have been subjected to such diagnostic procedures as cerebral angiography and pneumoencephalography. In some cases, particularly when pain is predominant in the anterior portion of the head, angiography has been done to rule out intracranial aneurysm.

In the typical case, pain appears within days or

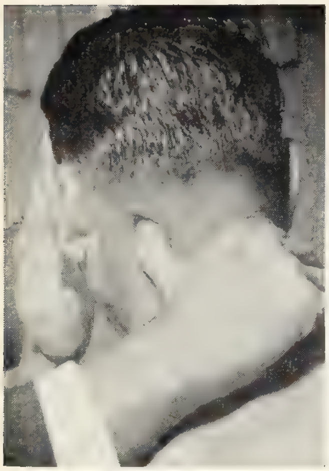


Fig. 2. Posterior view, illustrating point at which pressure is applied over the right greater occipital nerve in effort to reproduce symptoms.

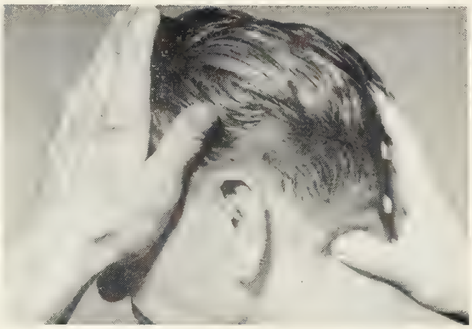


Fig. 3. Lateral view in same patient (see text).

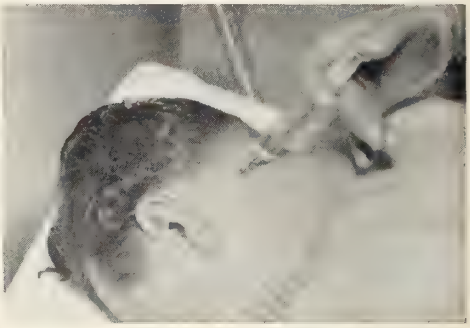


Fig. 4. Technic of injection, with patient in prone position. Tip of needle is kept in constant movement, to avoid appreciable amount of intravascular injection.

weeks of an injury of the type noted above. Often, seemingly insignificant blunt injury to the skull may be the initiating factor. Pain usually originates at the base of the skull posteriorly on one side, and less commonly, bilaterally. From this point, pain radiates upward and anteriorly to the region of the vertex or above the ipsilateral ear. There is frequent radiation of pain to the temporal, retroorbital and frontal regions. Pain may be constant, intermittent or paroxysmal in occurrence, and its nature may be described as sharp, aching, searing, throbbing, pressure-like or any combination of the foregoing. Frequency and duration of pain are quite variable, but the character of pain tends to remain unchanged. Intensity of pain varies, and it may be extremely severe and refractory to ordinary analgesics, and even to large doses of codeine.

On rare occasions, pain predominates in the anterior portion of the head, with a very minor or absent posterior component. It is particularly in these instances, and in the absence of remembered injury, that misdiagnosis is likely, and irrelevant major diagnostic procedures and inappropriate treatment occur.

* * *

ASSOCIATED SYMPTOMS may include a sensation of fullness and subjective impairment of hearing in the ipsilateral ear, although no gross impairment of hearing can be demonstrated. There may be subjective dizziness, but true vertigo has not been observed in this series. Less frequently, patients have complained of nausea and blurring of vision in the ipsilateral or both eyes. It is of interest that the treatment to be described has in most cases alleviated these symptoms as well as the head pain.

The frequency with which this syndrome will be recognized, particularly when one is familiar with its variants, is surprising. In addition to the obvious cases of traumatic origin, it is commonly present as a complicating or secondary manifestation of tension headache and osteoarthrosis of the cervical spine. In our experience, it appears to be the most common variety of unilateral head pain, far surpassing migraine in frequency.

Diagnosis and Treatment

A single, simple and apparently trustworthy procedure appears adequate to establish or rule out the diagnosis of this syndrome. Firm pressure, applied with the thumb over the greater occipital nerve at its point of emergence at the base of the skull (Fig. 2) will uniformly intensify or reproduce the pain, as well as the associated symptoms, to which allusion has been made. When pain is reproduced, the patient will in almost every instance state that it is identical with the spontaneous pain. This has also been observed in those cases in which pain is limited to the anterior portion of the head. The lateral view (Fig. 3) again illustrates the point of pressure. This subject is a middle-aged male with bilateral traumatic occipital neuritis, who is shown indicating the area to which radiation of pain occurs when pressure is applied.

Treatment is remarkably simple and effective, and consists in infiltration of the greater occipital nerve at the point of maximum tenderness with a long-acting, oil-based local anesthetic. The patient is placed in the prone position to ensure stability,

Head pain originating from the greater occipital nerve is frequently misdiagnosed and inappropriately treated. Pain may be unilateral or bilateral, and may be of traumatic or spontaneous origin. Pain is frequently most prominent in the anterior portion of the head and is of variable quality and intensity. Diagnosis is best established by reproduction or intensification of pain by digital pressure over the nerve at its point of emergence posteriorly. Treatment consists in blocking the nerve at this point with a long-acting local anesthetic.

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and digital pressure is applied over the nerve to ascertain the point of maximum tenderness. A twenty gauge, two-inch needle, attached to a lock-type syringe containing the anesthetic solution, is inserted perpendicularly at this point to the pericranium (Fig. 4). Withdrawal, sufficient to clear the point of the needle is done, and fan-wise injection of 5 ml. of the solution is made with deposition of 1 ml. below the posterior nuchal prominence. It has been found unnecessary to shave the skin of the scalp, and there have been no infections nor other complications. Local soreness at the site of injection has rarely lasted more than 24 hours.

* * *

RELIEF OF pain in most cases has occurred within minutes to several hours, and has usually persisted for many weeks or months, with permanent relief in a substantial number of cases. Our original procedure included trial nerve block with a dilute solution of procaine. If symptoms were relieved and then recurred, repeat block was performed with a long-acting solution. In recent years the latter has been used as initial therapy. Inadequate anesthesia may result from improper deposition of the anesthetic solution, and occurs less often as experience with this procedure is gained.

Analysis of Series

Our series comprises 57 cases of this syndrome, selected at random from our files over a period of ten years, and in whom follow-up over a period of many months to years was possible. The major diagnostic criterion, that is, reproduction or intensification of pain by pressure over the greater occipital nerve, was fulfilled in all instances. Results of treatment were considered satisfactory in those cases in which permanent relief of symptoms, estimated by the patient at 80 per cent or more, was effected.

On this basis, good results were obtained in 42 cases. In seven additional instances, good initial results were obtained, but symptoms recurred within a period of weeks to several months, and the patients did not return for further treatment. Poor results were evident in eight cases. Review of the histories of this latter group revealed that five were the subject of litigation which had not been resolved at the time of last follow-up. It would seem that poor results, in patients fulfilling the diagnostic criterion noted, are traceable to non-medical factors or to improper deposition of the anesthetic solution.

Case Reports

The following cases indicate several of the forms which this syndrome may assume, as well as the response to be anticipated with adequate treatment.

CASE I. A 49-year-old white male was hospitalized in 1958 because of severe, constant right-sided headache. Pain had been present since 1936, dating from a severe cranial injury, which was followed by unconsciousness for over one month and permanent deafness in the left ear. Pain was present with only occasional minor remissions, and daily medication for relief of pain had been required throughout this time. The pain was described as sharp and throbbing, most severe in the frontal region, with extension posteriorly to the region above the right ear and to the right occiput.

Examination revealed deafness in the left ear. Pressure over the right greater occipital nerve produced marked intensification of pain in the frontal region.

Nerve block resulted in complete relief for a period of four months, when a minor recurrence of pain was treated by the same method. A third injection was performed eight months later, and the patient then remained completely symptom-free until the time of his death from intercurrent illness in 1960.

This case illustrates headache of great duration, with rapid and complete response to specific treatment.

* * *

CASE II. A 46-year-old white male complained of recurrent right occipital headache for three years. No history of trauma could be elicited, except for a minor and non-disabling neck injury six years earlier. Pain was present almost daily, and appeared to originate posterior to the right mastoid region and spread up the back of the head. There was occasional mild pain in the right posterior neck.

Pain in the head was described as usually dull, and "like a skull cap," but occasionally so severe that "it would drive me crazy." X-rays of the skull and examination of the spinal fluid had been done. For two years he had received injections of vitamins twice weekly for treatment of "neuritis." Neurologic examination was within normal limits, except for reproduction of pain in the right side of the head by pressure over the right greater occipital nerve. After trial block of the nerve with procaine solution had proved effective, the procedure was repeated with a long-acting anesthetic.

The patient reported 19 months later that symptoms had been completely relieved, except for very slight pain in the right posterior neck, noted only when he lifted heavy weights.

This illustrates apparently spontaneous origin of this syndrome, with typical pain and response to treatment.

CASE III. A 31-year-old white male suffered severe cranio-facial injuries in an automobile accident in September, 1957, and was unconscious for several hours afterward. Injuries included fracture of the mandible and damage to the left eye, which was subsequently enucleated. Head pain had been present for 14 months following the injury, and originated in the right lateral orbital region, with spread to both frontal regions and backward on the left side to the posterior neck region.

Pain was often very severe, and accompanied by numbness of the left upper extremity, ringing in both ears, dizziness, general weakness and profuse perspiration.

Multiple scars were present about the nose and lips and the left eye was absent. There was tenderness to percussion in the left frontal region. The lower jaw deviated slightly to the left when the mouth was opened. There was moderate hearing loss on the left. Slight impairment of dexterity was present in the left hand and fingers, and a left Hoffman sign was elicited. Skin writing was poorly perceived in the left upper extremity. X-rays of the skull revealed no evidence of bony injury.

* * *

BECAUSE OF the severity of headache and the findings noted, the patient was hospitalized with a provisional diagnosis of chronic subdural hematoma. Electroencephalogram revealed a low voltage normal pattern. Right carotid angiography revealed no abnormality. Reexamination on the following day revealed considerable tenderness in the region of the right greater occipital nerve, and pressure in this area reproduced the patient's headache. Block of the greater occipital nerve was performed.

Follow-up examination 20 months later revealed that the patient had had complete relief of head pain throughout this period.

This case illustrates severe pain dating from a major head injury, and leading to suspicion of chronic subdural hematoma. With recognition of the etiology and appropriate treatment, response was excellent.

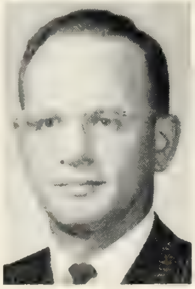
CASE IV. A 47-year-old white male suffered severe, recurrent headache for 13 years dating from a very minor blunt injury to the occipital region. Pain was bilateral and symmetrical, and originated in the occipital region, with radiation upward and anteriorly to both frontal regions, more severe on the right. Pain might last for several days, with remissions up to one month. It tended to occur with fatigue, emotional upsets, exposure to cold or heat, or excessive neck movement. Pain was described as throbbing, pressing and severe, and not relieved by ordinary analgesics.

Constant severe pain had been present for five days when the patient was seen. He was depressed and anxious. The posterior neck muscles were tender, and deviation of the head to either side produced pain in the opposite posterior neck. Pronounced tenderness was present over both greater occipital nerves, and pressure in these areas caused radiation of pain upward and anteriorly on either side.

Bilateral nerve block was followed by complete relief of head pain for over four months, following which minor pain in both occipital regions reappeared. However, he reported five months later that his symptoms were not of such severity as to require treatment, and stated that he had felt better than at any time in the past 13 years.

This case represents an instance of bilateral greater occipital nerve syndrome, occurring in association with tension headache.

CASE V. A 40-year-old white female presented with severe unilateral left head pain of many months' duration, readily intensified by pressure over the nerve. Attempted nerve block was unsuccessful. She was subsequently examined in a large



CO-AUTHOR
Seymour L. Osher, M.D.

clinic, where exhaustive investigation, including pneumoencephalography and carotid arteriography, was carried out. She was informed that no abnormalities were found, and headache continued unabated, despite continued medical treatment.

Two years later, she returned for follow-up examination, at which time head pain was again readily intensified by pressure over the left greater occipital nerve. Repeat nerve block was advised but this was declined by the patient.

This case probably illustrates failure of treatment due to improper deposition of the anesthetic solution. Her symptoms are typical, and it is regrettable that she refuses further treatment, which if done adequately, would almost certainly rid her of pain.

Review of Literature

Frequent reference to this symptom-complex is found in the literature, especially in connection with trauma to the head and neck. It should be pointed out that this presentation concerns itself with symptoms originating in the nerve itself, and is to be distinguished from the complete syndrome of the second cervical nerve root or other lesion proximal to the point of emergence of the nerve at the base of the skull.

Raney and Raney[1] commented on anterior radiation of pain in the head with pressure in the region of the greater occipital nerve, in a discussion of headache in association with herniation of cervical intervertebral discs. Subsequent studies, including those by Skillern,[2] Judovich and Nobel,[3] and Pietrobono, Allen and Walker,[4] also mention the mode of reproduction of pain, and describe relief of symptoms by local anesthetic injection.

The mechanism by which pain is transmitted to areas beyond the cutaneous distribution of the nerve remains the subject of speculation. Although Hunter and Mayfield[5] have shown that the territorial influence of the upper cervical nerves is more widespread than is generally realized, this observation alone does not suffice to explain the problem. Lesions in the mid and lower cervical areas have been found to produce facial and retroorbital, as well as occipital pain.[1,6] Skillern postulates transfer of sensory impulses to the descending root of the trigeminal nerve as a possible mechanism, and this concept would appear to have some merit, in view of the aforementioned observations. However, he was unable to abolish pain of this nature by trigeminal tractotomy.

Symptoms referable to the ear and labyrinthine manifestations might be similarly explained by transfer of impulses to adjacent vestibular pathways. Judovich and Nobel ascribe the referral of pain to reflexes set up by irritation of the occipital artery and its accompanying sympathetic nerve fibers, which lie in close relation to the greater occipital nerve. They comment on the simultaneous occurrence of tenderness of extra-cranial arteries (carotid and superficial temporal), but this latter has not been observed in our group of patients. Earnest[7] has described a case in which dizziness and other symptoms referable to the brain stem were relieved by rhizotomy of the second cervical nerve, and he believes that these symptoms resulted from sympathetic vascular reflexes set up in the posterior neck. The local pathology has not been defined, but it seems reasonable to assume that direct irritation or compression of the nerve and/or artery result from edema of fascial or muscular structures in this area.

Relief of pain by anesthetization of this area supports equally the neurogenic or vascular mechanisms which have been postulated.

Summary

From among the great variety of head pains, we have attempted to isolate and define a group which, for lack of a better term, might be designated as the "syndrome of the greater occipital nerve," and to describe some of its variants. Emphasis has been given to the frequency with which this type of pain occurs, following trauma, spontaneously and in conjunction with other varieties of head pain.

The distinguishing feature of this syndrome, and the basis of its diagnosis, consists in reproduction of the patient's symptoms by pressure over the affected nerve. The existence of this syndrome should be kept in mind in the differential diagnosis of head pain of any location, including orbital and facial pain, and it is suggested that the simple provocative procedure be incorporated into the routine examination of patients with head pain. A simple and almost uniformly effective method of treatment has been described.

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Effective treatment in bronchial asthma must be adjusted to the existing phase of the disease, according to whether the patient is in an acute attack, in status asthmaticus, in an acute emergency or in a state of rehabilitation. Unnecessary medication should be strictly avoided. The usual standbys in the treatment of asthma must be employed judiciously. They should be combined with such measures as bronchoscopic lavage, antibiotic therapy and short-interval hyposensitization, whenever indicated.

The Present Status Of the Treatment of Asthma

By
G. L. Waldbott, M.D.
Detroit

Since the discovery of antihistaminics and steroids which has substantially contributed to the comfort of the asthmatic patient, little new has developed in the treatment of asthma. However, some of the old therapeutic principles are being re-emphasized and new ones established.

These principles can be summarized as follows:

1. Avoidance of all unnecessary drugs.
2. Increased emphasis upon building up the patient's resistance to harmful antigens by desensitization.
3. Elimination of infection, both primary and secondary, i.e. that which induces asthma and that which is superimposed upon the allergic respiratory disease.
4. Efforts at rehabilitation of the asthmatic by subjecting him to normal activities.

Treatment will be dealt with specifically under four headings, namely: 1. The Acute Attack, II. Status Asthmaticus, III. The Acute Emergency, and IV. Rehabilitation.

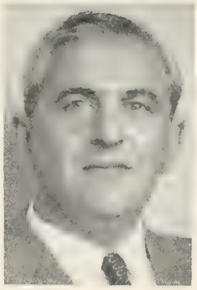
I. The Acute Attack

In dealing with an acute attack, there are three standbys: Epinephrine in doses of 1/10 to 2/10 cc. (1:1000). Intravenous aminophyllin in doses of 30 to 50 mgm. (about ⅓ of the 125 mgm. vial) given slowly, and injections of steroids. This treatment can be followed up at home by one of the numerous asthma compounds which usually consist of ephedrine, an antihistaminic and aminophyllin. Such medication should not be given routinely, but only when necessary. Sedatives, narcotics, salicylates should be given sparingly in asthma. Salicylates can be the source of extremely severe attacks when sensitivity to them exists. Indeed, whenever an asthmatic patient suddenly develops a severe attack, salicylates should always be considered as a possible cause.

II. The Asthmatic State

In order to break up status asthmaticus, withdrawal of former medication as much as possible is indicated. Three major measures are available for status asthmaticus, namely: intravenous steroids; antibiotics; desensitization with the dominant antigens, i.e. the pollein or fungi present in the air at that time.

As to steroids, I usually employ either 50 or 100



THE AUTHOR
G. L. Waldbott, M.D.

cc. of Solucortef dissolved in 50 to 1000 cc. of 5 per cent glucose once or twice a day. Forty units of Acthargel may be administered intramuscularly in support of this treatment.

* * *

ANTIBIOTICS ARE called for when there is leucocytosis, a high sedimentation rate, purulent sputum or purulent nasal discharge. The type of antibiotic is to be determined by antibiotic sensitivity studies of the sputum. In general, penicillin should be avoided because of the possibility that repeated injections may eventually sensitize the patient. An intradermal skin test with a small dose should always precede the administration of penicillin, even though the patient has used the drug without ill effect on previous occasions.

Short-interval desensitization, which is the administration of increasing doses of the dominant antigen currently present in the air, has been in my experience by far the most effective treatment to break up status asthmaticus. A chronic asthmatic state is not due to an antigen with which the patient has occasional contact such as animal hair or a certain food. It is the continuous absorption of an antigen from the air, particularly of pollen and certain fungi in summer, of house dust and fungi in winter that makes for protracted asthma. After carefully titrating the patient's tolerance to the respective pollen, the treatment should start with a dose below that which induces a wheal at the site of injection. Injections can be given three to four times daily.[1] The local edema at the site of injection is carefully watched. A trend to excess wheal formation or a generalized constitutional response requires prompt temporary discontinuation of the treatment.

During this procedure antihistaminics and epinephrine should be avoided because they interfere with the local response at the site of injection and thus with the proper gauging of subsequent doses. Aminophyllin does not influence the size of the wheal and might thus be utilized for relief of wheezing.

III. The Emergency

Emergencies arise not infrequently in asthmatic patients. They are due to two conditions, a sudden allergic edema in the respiratory tract involving either the larynx, the bronchial tree or the alveolar areas; I am referring to allergic shock in an aspirin-sensitive patient or in patients extremely allergic to peanuts, seafood, eggs, to animal dander, bee sting, penicillin and many other antigenic and non-antigenic agents. Here large doses of epinephrine supported by an intravenous antihistaminic to reduce the edema, and intravenous aminophyllin to counter the accompanying bronchospasm is the method of choice.

Most decisive is the speed with which epinephrine is administered. Even a few minutes' delay may be disastrous.[2] Intravenous steroids are not as effective as the other medications named. An extreme situation may call for intravenous epinephrine in doses of about 1/10 cc. (1:1000). It must be mixed with blood withdrawn from the vein and injected very slowly to avoid cerebral and coronary ischemia.

* * *

THE OTHER TYPE of emergency encountered is the climax of a gradually increasing dyspnea because the bronchial tree has become so filled with heavy inspissated sputum that no further air intake is possible. In this case bronchoscopic lavage is indicated as a lifesaving procedure.[3] No sedation nor anesthetic is needed as the patient is already unconscious. Extreme caution should be used with sedatives and local anesthetics which have occasionally led to fatalities during this procedure.

Since the bronchoscope does not enter into the fine ramifications of the bronchial tree, the injection of saline solution, to which a few drops of epinephrine and a cortisone solution is added, may help to induce bronchodilatation. By thus clearing the upper bronchial tree of obstructing mucus, normal breathing is dramatically re-established. The secondary bronchi begin to empty their contents into the upper bronchial tree which is now free of mucus. Subsequently, coughing and productive expectoration will further improve the patient's breathing capacity.

A recent experience has taught me an additional measure. A seven-year-old girl in a moribund state was about to undergo a bronchoscopic treatment. Respiration ceased before the patient was prepared for the procedure. An emergency tracheotomy was performed and a large amount of thick material spurted out from the trachea. Aspiration and lavage of the bronchi through the tracheostomy tube restored the child's respiration.

IV. The State of Rehabilitation

After subsidence of asthmatic attacks, an important phase of treatment should be initiated. It requires the reversal of many measures carried out during attacks.

Nutrition: The improvement of the patient's nutritional state is of major concern. Following an asthmatic attack, food items which were previously harmful can often be eaten with impunity. When possible, high caloric diets should be employed. Only those food items which have proven harmful should be eliminated.

Effort: An attempt should be made to improve the patient's threshold of tolerance to physical activity as soon as possible. Light exercise such as walking, climbing stairs, bending, squatting, at first with moderation and indeed with caution, should be initiated. This may be intensified should the patient remain free from attacks. At this stage even such activities as playing golf, bicycle riding, climbing, hiking and swimming—which have been previously harmful to the patient—should be encouraged. If not tolerated, they should be discontinued for days or weeks. Performance of normal activities, heretofore forbidden, constitutes a boost to the patient's morale which universally outweighs any temporary ill effect. By imposing too many restrictions on the patient we succeed in isolating him psychologically from his surroundings and induce serious inferiority feelings.

Cold Sensitivity: An attempt should be made to gradually build up a patient's tolerance to sudden temperature changes. I often recommend sponging of arms and legs with ice cold water and later rubbing ice on the body surface. The patient is encouraged to take cold baths in order to adjust himself to sudden cooling of his body surface.

The Psychosomatic Element: Some of the chief reasons for psychosomatic aggravation of asthma are the patient's fear of attacks, his concern about becoming asphyxiated, his habitual use of harmful medications, insecurity in his earning ability, inadequacy in his role as husband and father, the many "don'ts" which have been imposed upon him throughout his life by physicians, relatives and friends. Worried relatives, especially mothers in the case of children, contribute further to his insecurity. In other words, asthma is not caused by the patient's psychosomatic state, but the asthma renders him neurotic.

* * *

IN NO OTHER disease is the physician apt to contribute toward aggravating this situation as much as in asthma. Conversely, a physician may assist in alleviation of asthma of long standing through encouragement, proper counsel concerning the various aspects of the disease and through teaching the patient and his family an intelligent approach to the above problems. It is rarely necessary to refer him to a psychiatrist for lengthy—and costly—treatments.

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IN JULY . . .

August and ragweed are synonymous in Michigan. Next month's Michigan Medicine, therefore, appropriately leads off with the report on a new form of medication for the treatment of allergic cough as reported by Doctors Levin and Scherer of Detroit. The authors are both pediatric allergists on the faculty at Wayne State University College of Medicine.

In that same issue, Dr. Wayne Eaton of Flint reports on five years' experience with a cancer cytology screening program, and Dr. Peter Martin of Wayne State University presents an excellent paper based on sound psychiatric and psychoanalytic principles entitled, "The Problem of Identity."

Doctor Palm, from the Swedish Hospital in Minneapolis, in association with Doctors Carlson and Anderson of Iron Mountain, reports gastrointestinal hemorrhage in association with leiomyomas of the duodenum in two cases. Dr. Gilbert Galens of Birmingham reports two unusual cases of Felty's Syndrome, while Dr. Gerald Timmis, director of the cardiovascular laboratory at the Children's Hospital of Detroit, and his associates, present intriguing information on 166 infants with acyanotic heart disease.

These and other articles will present a broad spectrum of medical information of current interest.

Determine Cerebral Blood Flow

A way to accurately measure cerebral blood flow has been developed by two researchers, working on a Michigan Heart Association grant at Wayne State University Medical School.

The method utilizes a hollow needle inserted into a patient's jugular vein. Two thermistors attached to the end of a plastic catheter about ⅛ of an inch in diameter are pushed through the needle into the center of the jugular blood flow.

One thermistor is heated by low voltage electricity for five seconds. Then for 10 seconds its rate of cooling is measured by the other. The rate of cooling varies with the flow of blood; the faster the flow the faster the cooling. The electrical resistance of the thermistors, made of an alloy of silver with 10 other metals, varies with changes in temperature and are "fantastically accurate," said the researchers.

Doctors John Stirling Meyer, chairman of the WSU Neurology Department, and Fumio Gotoh, an assistant professor, have applied the technique to 78 stroke patients, as well as to epileptics, and other volunteers.

"This technique can determine the effect of drugs used in treatment of strokes," Doctor Meyer explained.

Funds supplied by the Heart Association, a Michigan United Fund Agency, are supplemented by the U. S. Public Health Service.

Recent Developments . . .

Community Mental Health in Michigan

By
Jose J. Llinas, M.D.*
Jackson

Changes in our ideas about mental health, the prevention of emotional disability and the treatment of mental illness are coming about throughout the country at a very fast pace.

As experts in the fields of disease prevention and treatment, as community leaders and as citizens, physicians should occupy a position of responsibility and guidance in the development of these changes.

A Brief History

What has been called the Mental Health Movement is relatively recent. It probably started on May 6, 1908, when Clifford W. Beers, the famous author of "A Mind That Found Itself"[2] organized the Connecticut Society for Mental Hygiene.[6]

The next year in Chicago, Dr. William Nealy, a pioneer of the Child Guidance idea, developed his Juvenile Psychopathic Institute for the psychiatric examination and treatment of juvenile offenders.

For many years prior to that, however, the most severely mentally ill had been, by tradition, a responsibility of the states. Many states, such as Massachusetts, in the middle and latter part of the 19th century, had created a system of fairly adequate mental hospitals.

In accord with ideas prevailing at the time, most of these mental hospitals were located far away from centers of population, so as to keep psychotic patients "out of sight and out of mind."

Psychiatry itself was then in a developing stage, and there was as little agreement about causes of mental illnesses as there was about their classification. In fact, no reasonable statistics were available until 1914, when the National Committee for Mental Health and the American Psychiatric Association developed a standard nomenclature, and some information about number of hospitalized patients and their kinds of disturbances was made public.

A number of hospital surveys were carried out, and finally in 1948, the American Psychiatric Association established a national inspection and rating system for mental hospitals. Ten years later, this responsibility was passed on to the Joint Commission on Accreditation of Hospitals.

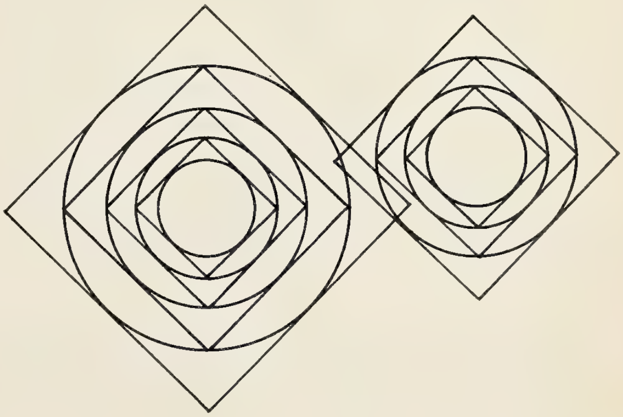
Michigan's Development

A review of the state's progress in the mental health field, up to 1964, was recently published by Peter A. Martin, M.D.[7]

"The first specific provision for mentally sick people occurred before it became a state," Doctor Martin says. "In 1834 the Board of Superintendents of the Poor of Wayne County authorized a special building for the *insane* at the Wayne County Poor Farm (Eloise)."

From these humble beginnings, Michigan was able to develop first a system of state hospitals: Kalamazoo (1859); Pontiac (1878); Traverse City (1885); Ionia (1885) and Newberry (1891).

One of Michigan's most important "firsts," was of course, the opening of the first psychiatric unit connected with a University Hospital in this country, the State Psychopathic Hospital in Ann Arbor



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*Medical Director, Beth Moser Mental Health Clinic, Jackson, Michigan. Chairman, Legislative Committee, Michigan Association of Community Mental Health Clinics.

THE AUTHOR
Jose J. Llinas, M.D.

(1906). It was the forerunner of the present well known Neuropsychiatric Institute.

The passage of the Hartman Bill in 1927 culminated in the construction of Ypsilanti State Hospital in 1931. This was followed later by the creation of a system of child guidance clinics.

For other important details about more recent history, the reader is again referred to Doctor Martin's excellent paper.

Worn Out Ideas

In what Nina Ridenour[6] describes accurately as one of the most regretable "if onlys" in American history, President Pierce vetoed a bill in 1851 which would have appropriated ten million acres of public land for the **Indigent Insane,** comparable to the 100 million acres earlier given to the states for the purpose of extending high education, and from which the land grant colleges grew.

There was a marked lack of interest in the plight of the insane, as the severely mentally ill were designated then. It would take more than a hundred years for this situation to be corrected.

The concepts that mental illness was a strange and unpredictable disease, that people who became mentally ill almost never recovered, and that they had to be kept in big hospitals away from contact with the rest of the population, were all stumbling blocks in the path of a more dynamic and scientific approach.

Winds of Change

The beginning of the Child Guidance Clinic movement, with its emphasis on behavior disturbances in children ("juvenile delinquency") was a great step in the direction of trying to reach patients earlier, and doing this at their own community level.

Mental health clinics for children and adults number now approximately 1600. Since 1959, the National Institute of Mental Health has been collecting data on many aspects of the population these clinics serve, and their treatment results.

In 1955 Congress appropriated funds for a special commission to study all the problems regarding mental illness in the United States. For five years some of the best known experts in the field were hard at work. They finally came up with their now famous report, "Action for Mental Health," in 1960.[1]

Action for Mental Health

As has been previously suspected, the Commission reported, it is not necessarily the symptoms of mental illness that send a patient to a mental hospital, but *the fact that other people can no longer stand his behavior.*

And, once in the hospital—especially if it is state run, the patient's care may be largely punitive and custodial, not therapeutic.[1]

"One of the most revealing findings of our mental health study is that comparatively few of our 277 state hospitals—probably no more than 20 per cent of them—have participated in innovations designed to make them therapeutic, as contrasted to custodial, institutions."

The Commission also recognized openly the patterns of "social rejection" against the mentally ill. Nobody, not even the doctor, seems to like the severely mentally ill.

Part of the reason for this is that, unlike other sick people, the mentally ill do not reach out for help, nor do they clearly manifest gratitude when help is given. Since the essence of mental illness appears in disturbed behavior, these patients seem to bring about responses of rejection and unfriendliness.

The Commission stated that this problem should

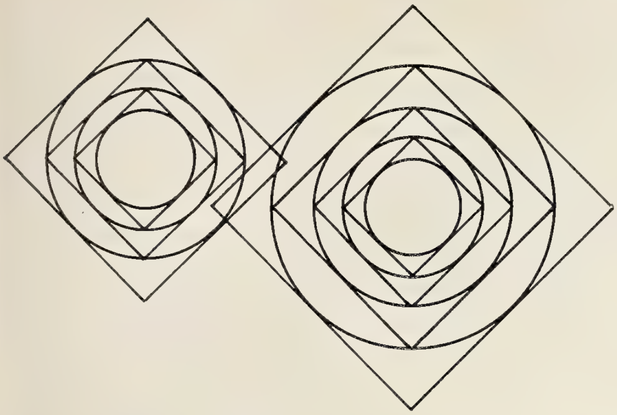
AVAILABLE FROM MSMS

Members of MSMS may obtain copies of two mental health booklets from the MSMS Headquarters, as long as the supplies last.

Members may write to MSMS, Box 152, East Lansing, if they are interested in the following:

"Proceedings of the 1964 MSMS Congress on Mental Illness and Health." The speakers included Marvin E. Perkins, M.D., New York City Commissioner of Mental Health Services, who discussed "Community Mental Health and Facilities."

"The Comprehensive Community Mental Health Center" booklet published by the U. S. Department of Health, Education and Welfare.



be met head on, and that the resources of the entire nation would have to be tapped to combat this, our number one public health problem.

Community Mental Health Service Acts

As a result in part of the study, community mental health acts, under which the state agrees to help local areas to develop adequate services, gained momentum. The pioneer state was New York, which had passed this type of legislation four years ago.

More recently, Congress passed legislation (P.L. 88-164) enabling the states to obtain matching funds for planning community mental health programs.

Michigan's Public Act 54

This bill, passed by the legislature in 1963, provides for matching funds from the state to local communities, for the development of comprehensive mental health services, that is, a system of psychiatric facilities (not simply "a clinic") for diagnosis and treatment of acute and chronic conditions, consultation to agencies concerned with mental health (schools and courts), emergency services, day care, night hospitals, etc.

Essentially, the decision to establish or participate in a community mental health program is left to the discretion of the County Board of Supervisors, or, for a city of 500,000 or more population, the city council.

When official action has been taken by a city, county or combination of counties, to establish a service, a 12-member community mental health board shall be established, this board to work in cooperation with the State Department of Mental Health.[5]

At the present time, many communities in Michigan have taken this step. In still many others, study committees have been named by the Board of Supervisors, by the United Community Services, or by both, to investigate the mental health needs and resources of the particular community.

It is here that doctors, with their knowledge and experience, both as professional people and as citizens, can contribute the most.

The bibliography at the end of this brief paper may serve as a guide line for the development of further knowledge in the field. A brief note to Dr. Robert Kimmich, Director of the Mental Health Department, Lansing, will bring literature and further information.

Summary

As the new community mental health legislation (P.A. 54) is put into effect, many changes in the mental health picture of the state and each one of our communities will come about. It is very strongly recommended that physicians take a part of leadership and cooperation in bringing these changes about.

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AVAILABLE FROM AMA

The AMA has published three companion publications of interest to physicians concerned about mental health. Copies of each are available from the AMA, 535 N. Dearborn Street, Chicago 10, Illinois. They are:

"AMA Statement of Principles on Mental Health"

"Program of the Council on Mental Health"

"Summary of the Program of the Council on Mental Health"

* * *

Coincidently the art design used in this article is the symbolic art used by the AMA on these three pamphlets.

Special Communication

The subject "medical hypnosis" calls for thorough study against the background of this basic medical wisdom: Every patient's conscious use of his power of self-helpfulness is most efficacious. Hypnotic control always slights each healthful ideal: the whole patient and the whole physician. Authoritarian hypnosis diametrically opposes hygienic education, namely, responsible self-experience. Everyone's sense of wholeness is sanitary.

HYPNOSIS

. . . Every Individual's Educational Problem

By
John M. Dorsey, M.D.
Detroit

My awareness for the widespread use of hypnosis by my fellow man, child, or adult, for diversion, and even by my earnest religious educator and fellow physician, prompts me to indicate certain of my perceptions about this "fascinating" subject.

First of all, as ordinarily conceived, there is no such possibility as "hypnosis" or "suggestion." All suggestibility is self-experienced entirely. All hypnosis is autohypnosis entirely. Each is nothing but the power of an individual's unconscious will, the power of his living which he does not recognize as his own living. Each individual is an all—that means that there is nothing for him to hypnotize or be hypnotized by, but himself.

By hypnotizing myself I set up in my own living: (1) the controlling power of myself which I cannot recognize as mine (my hypnotist), and (2) the power of myself which I recognize as mine, but consider too weak to control my behavior. Under my autohypnosis I command and obey my own directions.

As James Rowland Angell wrote of hypnotism in 1900, "there is among even the scientific students of the subject radical difference of opinion on a number of fundamental points." Certainly my own mind has undergone many different modifications bearing upon the procedure, so that I can identify myself readily with my colleague who hardly knows how to make up his mind about it. No matter what the apparent occasion for my dissatisfaction may seem to be, however, it helps me to realize that all of my life's unhappiness has been symptomatic of my unwillingness to see that I must abide peacefully in my mind's own living room. Pascal noted, "By space the universe encompasses me and swallows me up like an atom; by thought I comprehend the world."

* * *

I LIVED many years as a physician before I could realize the ubiquity of so-called "suggestibility" in my world. Before I was capable of this overwhelming realization, I had to figure out for myself the meaning of "suggestion," for I could not see it clearly then as all and only illusion. Rather I conceived it to be some kind of magic suspension of the law of identity wherewith one individual (all) could influence another individual (all).

As my appreciation of the inviolable wholeness of individuality grew, I gradually came to recognize that all of my suggestion had to be the exertion of my own self power unrecognized as such, and hence conveniently attributed to my (own) fellow man.

In other words, I had been in the habit of using the notion "suggestibility" to account to

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Doctor Dorsey is University Professor, Wayne State University.

myself why my own rejected selfhood (my "not-I" demesne) still had meaning for me even though I could not acknowledge it as integral to, and for, my peacemaking sense of personal identity.

Words are unequal to my wish to picture the force and frequency in my world of this immediately helpful illusional living known as "suggestion." To begin with, it seems to be not only most "respectable," but most sought after for its comforting nature. Wherever a person cannot see his own personal identity in his living, there immediately the illusion "dependence upon another" (suggestibility) sets up and takes over.

* * *

THE MORE of my life experience I cannot responsibly classify as the fruit of my own living and localize in the region of my being, the stronger and less disciplined is my suggestibility. Bernheim described suggestibility as nothing but one's tendency to transference living, that is, to living as if one's life were not all and only one's own, as if one's individuality were not inviolable.

I take pains to observe this universality of so-called suggestibility, or "alien influence," in my world for it is only against that background that the so-called popularity of hypnosis, the misprision of man's individual liberty, can become understandable. It is only a short way from one's habitual dependence upon experiencing his suggestibility to his ungovernable appetite for undertaking and undergoing autohypnosis. The less strict and extensive my realization of my own personal identity, the more I must live my own life's experience as if it does not belong to me.

My suggestibility illusion facilitates my transferring my attention to and from my own acknowledged and unacknowledged mental functioning. In other words, my suggestibility is a symptom of ignored or rejected selfness. It bridges over my own recognized and unrecognized living of myself, permitting my awareness for my own mind's meanings which I cannot accept as integral to my personal identity. Whatever I live as if foreign to me, is my "transference" living. Quite as Sandor Ferenczi indicated, my suggestion is my process of influencing myself through my so-called "transference" living (see Ferenczi's, *Introjection and Transference).* The absolute requirement of the psychoanalyst is his renunciation of transference living (including suggestibility). He must see his own creativity as the provenience of his all.

Prevalence of suggestibility necessitates exactly corresponding prevalence of authoritarianism. Again, I cannot sufficiently picture the vast extent of the craving for authoritarian living now loose in my world. Thence arise the blind demand for, and idolatry of, specialists of every kind to whom one may (delude himself that he can) relegate his responsibility for his health and chances for happiness "in this world and the next."

To renounce my suggestibility I must strive to feel certain self-property in my every experience, and to exercise sovereignty over myself. I must sense repression, that is, efforts at life-negation, in all qualities however tempting which have not the foundation of life affirming self-observation.*

* * *

IT REQUIRES the hardest kind of mental discipline to see "suggestibility," or "authoritarianism," lovingly for what it is, so that it can be renounced. All of the so-called "evils" of superficial education derive from learning for which the learner does not hold himself personally responsible as his conscious self-knowledge. As St. Augustine observed, thought is inseparable from self-knowledge. All that is meant, or can be meant, by "moral training" is the recognition that one can experience only his own living of his own world.

I live my American physician's way of life responsibly when I ask myself, how does "hypnotism" accord with (my) Thomas Jefferson's Declaration of Independence?

How does my blind suggestibility harmonize with my forefather's ideal of the **indwelling** sprit of his individuality?

How can I collocate devotion to the soul of human creaturehood (for example, of my Anne Hutchinson, Mary Dyer, Roger Williams, Ralph Waldo Emerson, Henry Thoreau) with ignoration of the fact that only I can grow my own every influence?

With all of the current urgency for relief from the austere truth of self-helpfulness, I am reminded of Emerson's civic-spirited hypnosis-free tribute to his Quaker friend, "Ah! if she had said yea, and the whole world had thundered in her ear nay, she would still have said yea."

Each of us considers his United States the great melting pot to which nothing can be foreign. Otherwise, I might introduce the charge of foreignness against a doctrine which is based upon the illusion

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*Repression is my imagination's condemnation proceeding, a prohibition which creates an emphasis. My repressed power seems to me to be involuntary. My renunciation is loving appreciation of whatever I live. My renounced power is ever accessible to me as volitional.

THE AUTHOR
John M. Dorsey, M.D.

that one mind can dominate, or be dominated by another.

* * *

HOW INCONGRUOUS is the practice of hypnotism to the ideal American way of life! Hypnotism is a wail of the day recommended as all-heal by one or another who, without realizing it, puts his comprehension of, and devotion to, his American freedom in gravest peril. The medical hypnotist reminds me of Paracelsus' fable of the traveler who bore his household goods to the wrong shore, building his beautiful ideal of the dignity of the individual on the unreliable morass of suggestibility.

> *It may well be that man's turning backward to the use of hypnosis represents his understandable recoil from his discovery of the uncompromising forward truth: the only possible help is self-help.*

My life often seems threatened by frivolity I must live, the trivial indistinguished from the tremendous.

Mind wise living is healthful.

* * *

A MIND WISE person, a scientist of his own mind, sees clearly that he cannot be influenced except by what **natively** commands him, his intuition. He observes his imagination as subsuming his mental power, and intends to identify himself with every use of his mind. He sees clearly that his notion "hypnotic therapy" is self-contradictory. He cherishes above all his severe declaration of independence, renouncing his ever-present temptation to sham subjugation. His tendency is to seek proof of himself, not to hide behind his appearances of inauthentic "otherness" (e.g. "a hypnotist"). In sensing his own identity he senses his excellency. In renouncing hypnosis he recognizes he is renouncing an illusion only.

Undoubtedly favoring its popularity are the **seeming** advantages of hypnosis, particularly the ease and pleasure associated with it. It seems so simple and even delightful to "go under," and the liking for it is so readily acquired. For the hypnotist, the illusion of power over another can be most appealing as a "turning of tables" from his earliest living as if "under the power" of his parent. Every Coué may have his day.

* * *

SEVERAL YEARS ago, as if his careful mind could foresee the present turmoil about the subject, our own Dr. Raymond W. Waggoner invited experts on hypnosis from far corners of the country to our Michigan Clinical Institute to discuss the rightful place of hypnosis in medical work. Caution and more caution was each expert's expressed attitude. May such educational opportunities be ever continued.

Arguments supporting medical hypnosis, however, have always been many and strong. In fact, I know of only one unanswerable argument against it, and that one is too seldom used, namely, the welfare of the mind itself. Whenever I deny responsibility for any of my own living, e.g., by claiming I made someone else do it, I practice self-deception. Self-deception develops my mind's capacities for unrecognized dissociation so that I function as a house divided against itself.

> *Conscious mental integration, not the unconscious mental dissociation called "hypnosis," describes my most healthful mental living. It provides me with my whole appreciation of my personal identity and thereby spares me unacknowledgeable mental divisiveness known as mental disorder.*

My practice of hypnosis depends upon my devotion to my illusion of duplicity, not to my truth of my unity. Hypnosis exercises my power of self-deception, thus obstructing my consciously integrating my mind as my own, and thus setting up in my own mind the illusion of power foreign to me. Therefore, I willingly renounce its use.

* * *

THE HEALTHIEST mind is the one which is most self-tolerant, the one which can sense its own identity in the most of its activities, the one which sees the most of its experiences as taking place within itself. Conversely, the mind of most restricted health enjoys the least self-tolerance, the narrowest appreciation of personal identity, and the most frequent location of its own mind's happenings as if they could occur elsewhere.

By living my life as if it is not my own (by defining it "not-I") I impoverish my volitional power, restrict my conscious control of myself, augment my involuntary behavior, and enjoy self-esteem limited to part of myself only. My self-love can be the fiercer the more I thus concentrate it. Then it can seem to me that I can have power

over my fellow man, or he over me; control him, or he me; influence him or he me; in short, hypnotize him or he me.

If there is any one principle for which every American M.D. may sanely stand it is that of seeing the end of man's existence to be his preserving, cultivating and enjoying the individuality of his mind. One's practice of hypnosis is directly and unequivocably opposed to his constitutional (physiological) ideal of self-sovereignty.

What can it profit a man to seem to rid himself magically of any complaint if by so doing he must forego the conscious use of that much of his sense of wholeness. His complaint is ever his counselor, his guardian angel. His autohypnosis lulls him to sleep away his volitional access to his **own** power and attribute mediocrity to his existence. Hypnosis is not based upon voluntary activity, but seems imposed as if by alien authority.

* * *

WHEN I CONSIDER what deliberate use of suggestibility or hypnosis signifies, namely, the pretense that man is a means and not an end, I notice how peculiarly unsuitable it is for American medical work.

However, I am not hostile to hypnosis. True, I see it as a "treatment worse than the disease" it purports to treat. I recognize that its "apparent" advantage seems to please everyone whose idea of health is the avoidance of distress, whose idea of happiness is the avoidance of unpleasant life-experience, and whose estimate of hardihood is that it may be secured in some way other than by undergoing hardship. It is thoroughly understandable that human endurance may not be seen as man's greatest human achievement. I am content that my fellowman help himself in the only way he can and that he take just pride in **his** kind of self helpfulness pending his finding it helpful to add to it.

Research, the love of facts of one's life, and the representation of all education as research, is my solution for my life's problems, including this very dangerous one of my fellowman's indulgence of hypnosis. All of my medical science is based upon the necessity to individualize, to renounce generalizing.

For example, I must learn to live with full respect my fellowman, each one, whose current way of helping himself is through "hypnotic" experience. Only by being this kind of fact-finder can I work up my **helpful** understanding and then proceed helpfully in terms of my facts. Describing a cure for hypnosis, through discovering the wholesome factuality of self-consciousness, exceeds the scope of my present intention. Only by being a fact-finder can I avoid being a fault-finder. My fault-finding has consistently proved to be my most costly kind of helpfulness, except when it has finally been kindly understood as my crying out "Ouch," and thus led me to study the facts accounting perfectly in every possible way for the so-called "fault."

* * *

EVERY AMERICAN is free, free even to prison his American ideal of self-government in the shifting shrine of suggestibility. But I have found that it is impossible to live unwisely, once I educate myself to wise living. Meanwhile, it is but natural to wish away through prohibition such irresponsible infatuation as hypnosis. Prohibition which is based upon so-called "external coercion" may be tried, but the human mind is against such self-disregard. It may through this very prohibition derive emphasis. In such event the whole issue of suggestibility and its pure culture, autohypnosis, may develop obsessive and compulsive force.

Every M.D. may be an authentic, not authoritarian, educator. "Docere" means, to teach. Every roused physician may make up his mind to renounce hypnosis wherever and whenever possible on the basis of its being incompatible with fullest respect for human life (human individuality). In the interest of his public health he may point out his concrete knowledge that the force of autohypnosis is diametrically opposed to the force of democracy. With such self-contained, self-directed self-helpfulness as a possible source of continuous educational opportunity for the enlightened layman, there is real promise of his gradual renunciation of his suggestibility indulgence.

With each of my colleagues I am alarmed at the incidence of "wild" hypnosis, the completely uncontrolled practice of deep suggestion by the person of slight conscious responsibility for his world. The need to "make things pleasant" is akin to the need to "bewitch," to "charm," to "fall in love" and to be "carried away." "Attracting," "captivating," "seducing," "enchanting," "entrancing,"—each such word derives its force from feelings deeply rooted in each individual's nature, from feelings also which can be expressed in undisciplined "authoritarian" "suggestive" ways. The problem thus posed is truly a grievous one. There is comfort in the fact that it subsumes all of the problems obstructing conscious self-development for complete self-fulfillment.

Most difficultly, through self cross-examination, I have learned my lesson of reality, namely, my regarding every human problem as one of a human individual only, to be resolved only *by that individual's consciously educating himself to discover its solution within his being.*

Education as conscious self-development, the very antithesis of hypnosis, is the hygienic learning force.

Comes to mind Horace Mann's condensation of Emerson's self-lessons for his young fellow man: (1) sit alone, and (2) keep a journal. Tempted as I am to generalize, pass sweeping laws, condemn whole "classes of people," inflame "public indignation against uncaring hypnotists,"—I must try to see each such impulse as understandable complaint temporarily threatening my mental equilibrium. For I know in my heart of hearts that every kind of hypnosis is a genuine product of one human nature, that reverence for the sacred integrity of human individuality occurring with the force of education as self-experience will accomplish what nothing else can accomplish: the exalting of suggestibility-free, authoritarianism-free, joy of living human individuality.

* * *

EVERY HUMAN performance proceeds out of the depth of a human being, and consciousness for that truth is the measure of one's realism in considering any and every human act. In the living of my medical problem I resort to fact-finding; in the living of my surgical problem I depend upon detailed respectful study of the existing conditions; and in the living of my wider human affairs I do well to welcome cheerfully whatever further fact-finding work presents itself.

Whatever is, is good—for its very foundation is the medicinal necessary. Devotion to the life of continuous self-education is no sweet asylum. Of all ways of life, it is the most difficult just as it is the most rewarding. It alone enjoys the full sanction of human nature.

Said that world of a man, Thomas Jefferson, "Health is no more than learning."

In conclusion, all consciousness of course is self-consciousness. Therefore, universal convincing proof of the existence of the unconscious mind is found in anyone's not seeing **only** his selfness in any of his living of his experience. From these two statements I can see how extensively I live my own mind unconsciously and, it appears to me, how unconsciously my fellow man lives himself. However, the systematic employment of my unconscious mental power called "hypnosis" is quite another matter.

The hypnotic experience of man has a long and honorable history in calling his greatly needed attention to the body as being a mental agent. For example, from the study of hypnotic behavior has evolved (1) the concentration of the Christian Scientist upon the powerful force of his mental condition in controlling his general health, (2) the psychiatrist's appreciation of his mind's situation for enabling his realization of the wholeness (including healthfulness) of his being, and (3) every physician's recognition of the tremendous meaning of his patient's use of his mind for educating himself in the hygienic direction of appreciating his life so that he will responsibly take care of his health. The present flare for irresponsible hypnotic living may be interpreted as every symptom properly is, namely, as helpfully indicating (1) how the patient is already trying to help himself and (2) how the patient may beneficially add to his self-helpfulness. Certainly his turning to some kind of methodical use of his mental power (however shortsighted) may be construed as laying a foundation for a reliable, responsible, independent use of his mind which respects the dignity of his individuality.

Find Alcoholics Cause Half of Fatal Auto Accidents

One-half of fatal traffic accidents are caused by chronic alcoholics, most of whom have severe psychiatric problems that immunized them against legal threats and educational appeals.

That conclusion, based on a Washtenaw County study, was voiced by Melvin L. Selzer, M.D., and Mrs. Sue Weiss, of the Neuropsychiatric Institute at The University of Michigan Medical Center, at the recent meeting of the American Psychiatric Association in New York City.

They reported on psychiatric investigation of 72 persons judged responsible for fatal accidents which claimed 87 lives during a three-year period. Much of the evidence on the drivers was collected posthumously, from interviews with persons who had had intimate knowledge about them.

Thirty-six of the 72 were alcoholics and pre-alcoholics. All but one of these, plus 31 per cent of the non-alcoholics, had been drinking immediately before the fatal accident.

Forty-two drivers had recognizable psychiatric problems other than alcoholism. The most common symptom was paranoid thinking.

Two of the 29 alcoholic drivers had been responsible for a previous traffic death while they had been driving in an intoxicated state. In addition, eight of the alcoholics had accumulated 17 previous convictions for drunk driving; 10 had prior convictions for drunk and disorderly behavior.

Three of the 72 drivers were driving without a license.

MSMS Centennial Series: 1963, 1964

Mr. Brenneman Chosen to Succeed Mr. Burns

Leading up to the MSMS Centennial in 1965, The Journal *is printing a series of articles by William J. Stapleton, Jr., M.D., Detroit, who is the MSMS Historian. This series began in the September, 1963, number of* The Journal *and will continue through August, 1965.*

1962-63

Doctor Clarence I. (Red) Owen has had a distinguished career as a pathologist, teacher and as Editor of the *Detroit Medical News.* He has been President of the Detroit Academy of Medicine and President of the Michigan State Medical Society. He has always been active in the advancement of medicine, and has been particularly interested in the postgraduate work of the MSMS.

Doctor Owen was installed by the 1962 House of Delegates. Meeting in Detroit, the Delegates acted on many matters, including:

—Established a committee of the House of Delegates to receive the Relative Value Study report and at its discretion conduct an opinion survey of MSMS members to obtain reaction on the report, using every possible means to get the RVS report thoroughly understood. The committee is to have such other functions as the Speaker may decide and to report to the House at its regular session of 1962,

—Directed the Speaker to appoint a committee of House members and members of The Council "to determine those relationships between osteopaths and medical physicians that require exploration and the methods whereby such exploration can most profitably be carried out for the public good," and to report recommendations of the 1962 session of the House,

—Established a committee of the House of Delegates to award "Certificates of Commendation" to one or several physicians annually, replacing the "Foremost Family Physician" award,

—Recommended fulfilling commitments to Michigan's present two schools of medicine and expansion of their facilities prior to establishing any new school,

—Urged all component medical societies to immediately create Medical Socio-Economic Committees to act as subcommittees of the MSMS Medical Socio-Economic Committee.

Clarence I. Owen, M.D.
MSMS President 1962-63

Orlen J. Johnson, M.D.
MSMS President 1963-64

The Author
WILLIAM J. STAPLETON, JR.
M.D.
MSMS Historian

* * *

NINETY-FOUR items were considered at the Annual Meeting of The Council January 25-26. One of the most important actions was: "The Council endorses the unanimous recommendation of the Legal Affairs Committee that the MSMS publicly support the proposed Michigan constitution." The Council also requested the chairmen of the Michigan Delegates to the AMA to use their influence to increase the representation of Michigan Doctors of Medicine in the councils and committees of the AMA.

There was a brilliant story in the January *Journal* of the life of Doctor Coller and his contributions to medicine and especially surgery. We hope all our readers will read this tribute to one of whom the author says, "Surgery has been considerably enriched by his career. Doctor Coller has accelerated beyond measure the advance of surgical science began in this country by William Stewart Halstead."

The May issue of *The Journal* was filled with a special series of articles about Geriatrics. The MSMS Geriatrics Committee offers scientific articles about the care of the aged in institutions.

* * *

ONE OF THE highlights of the year was the

100th Anniversary of Harper Hospital. Among the numerous activities was the medical symposium held at Wayne County Medical Society headquarters with national authorities in the field of medicine and surgery. The celebration ended on May 1 with a banquet of 1,500 friends of Harper Hospital at Cobo Hall.

The spotlight in May was also on the Grand Rapids Health Fair and the annual Michigan Health Council Conference.

Wilfrid Haughey, M.D., one of the founders of Michigan Medical Service and Editor of *The MSMS Journal* for many years died in July. The September *Journal* carried a well-deserved tribute.

Personally, I was interested in the August article entitled "The Medical History of Saginaw" by Edward F. Kickham, M.D., of Saginaw. It might be well if all county societies should use this paper as an example by which their own local society's activities should be set down for our medical history.

1963-64

The 1963 House of Delegates acted on many important matters in charting the course for 1963-64. Let me report only a few:

—Adopted a five-point guideline for emergency care in hospitals dealing with the responsibilities of the staff in connection with the emergency room, and directed that it be distributed to all hospital chiefs of staff and published in the *County Society Letter*. The standards for emergency departments in hospitals formulated by the American College of Surgeons is commended to all hospital medical staffs in Michigan,

—Urged all component societies of MSMS to encourage and participate in community activity to observe "Community Health Week," October 20-26, 1963, and pledged full MSMS support in cooperation with the Michigan Health Council and the Michigan Association of the Professions,

—Highly endorsed, and urged participation by all MSMS members in the "Operation Hometown" campaign to be conducted jointly by the American Medical Association and MSMS,

—Changed the Bylaws to permit active membership in MSMS and component societies by doctors of medicine who are engaged in academic or industrial teaching, research or administration,

—Adopted a "policy of professional respect for and cooperation with the Michigan Association of Osteopathic Physicians and Surgeons, Inc., in those areas of common responsibility and common interest where such cooperation can be of benefit to the people of the State of Michigan,"

—Resolved that the Relative Value Scale (RVS) be not implemented at this time by MMS, that it be restudied by the present RVS Study Committee, and that any revised scale be submitted to MMS "for monetary interpretation without implementation" and returned to the House of Delegates at a special, or the next regular session.

—The House presented a new automobile to William J. Burns, retiring executive director, who completed 24 years on January 1, 1964.

* * *

THE COUNCIL selected Hugh W. Brenneman, our PR Counsel, to become the new Executive Director as of January 1, 1964, and named Warren F. Tryloff as Associate Director.

The Council on November 30, 1963, authorized a contract with Cobo Hall for the Centennial Annual Session for MSMS in September, 1965.

Michigan Clinical Institute featured a panel discussion on "Medicine and Religion." (An interesting addition to the MSMS list of committees is the one entitled "Medicine and Religion.")

Attendance at the Michigan Clinical Institute surpassed recent years. The registration totaled 1,138. The total registrations of doctors, interns, residents, students, nurses and others totalled 2,295.

* * *

WAYNE STATE University began a series on Ethics and Jurisprudence, an important addition to our Postgraduate Course.

Thanks was given to MSMS for the operation of a First Aid Station for the Legislators.

I hope all our readers will read the opinions of Lester P. Dodd, Legal Counsel of the MSMS in the March, 1964, issue of *The Journal*. He explained the implications of delegate work. Very Important.

Plans were formulated for the proposed Michigan Health Fair in 1966. Contacts were started with the schools.

* * *

DOCTOR JOHNSON wrote some provocative President's Pages in *The Journal* including June, devoted to the topic "Quality of Medical Care." He ended his article by saying "Quantity should not replace quality or be the criterion of good medical practice."

A Mental Health Congress was held in Detroit on June 26.

July brought the first issue of MICHIGAN MEDICINE, the journal of the Michigan State Medical Society, as it is now called. The Council, the Publication Committee, the Scientific Editor, Charles J. Tupper, M.D., and especially the Managing Editor, Herbert A. Auer who has done a marvelous job of face lifting to *The Journal*. There are some 14 specific changes in *The Journal*, all adding to the readability.

Offer Film

"Reprieve," a 16-mm color motion picture sponsored by the Public Health Service, U. S. Department of Health, Education, and Welfare, is available on loan free of charge by writing to the Public Health Service Audiovisual Facility, Atlanta, Georgia 30333. The 22-minute film offers hope and encouragement for the million-plus American men and women who each year survive a heart attack.

Centennial Session

Michigan
State
Medical
Society
1866

September 19-24, Detroit

Celebrating
A Century of Service in Medicine

Every member of MSMS is cordially invited—and urged—to participate in the Centennial Session of the Michigan State Medical Society in Detroit, September 19-24.

The special days of the MSMS Centennial Session will pay tribute to the great segments of American society which complement and support the work of Michigan doctors of medicine. Truly, today's medical care is the work of many hands, many minds and many hearts.

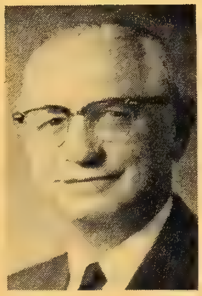
Activities of the MSMS House of Delegates, the MSMS Sections, the Ancillary Organizations, and others will consider the position of the medical profession today in the light of both its scientific and professional attributes. Guide lines for future action will be developed.

Michigan physicians will want to come and hear more than 124 outstanding scientists and teachers who have accepted invitations to speak at the four days of scientific sessions at Cobo Hall. This year, for the first time, the Scientific Program will begin on Tuesday and continue through Friday.

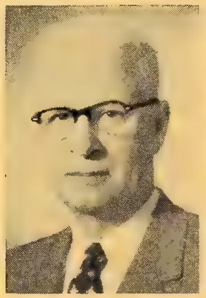
Each day will be a convention in itself, replete with scientific, professional and social events. Joining the physicians in Detroit for special events will be the Auxiliary, the Medical Assistants, other Scientific Organizations, the Voluntary Health Groups, and leaders from Business, Industry, Communications, Religion, Government and other allied areas of human concern.

Please block out your office calendar now for September 19-24 and make your room reservations direct to the Sheraton-Cadillac Hotel in Detroit. And watch your mail for detailed information.

MSMS
President
Oliver B. McGillicuddy, MD


MSMS
President-Elect
Luther R. Leader, MD

Speaker, House of Delegates
James J. Lightbody, MD


Chairman
MSMS Council
Harold H. Hiscock, MD

Chairman, Centennial Session
C. Allen Payne, MD

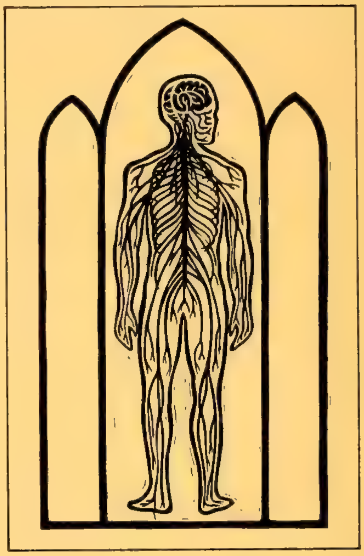
Chairman, Scientific Program
Harry H. Towsley, MD

COME AT LEAST ONE DAY DURING CENTENNIAL WEEK

Sunday, September 19

Medicine and Religion Day

- Profession and public invited to impressive Medicine and Religion Convocation; First Session also of House of Delegates; 3:30 p.m., Ford Auditorium; Panel of William Menninger, M.D.; Rev. Paul McCleave, of AMA; 150-voice choir
- Walter Judd, M.D., speaker, at Evening Session of House of Delegates
- MSMS Council Meeting



INDUSTRY
BUSINESS
MEDICINE
COMMUNICATIONS

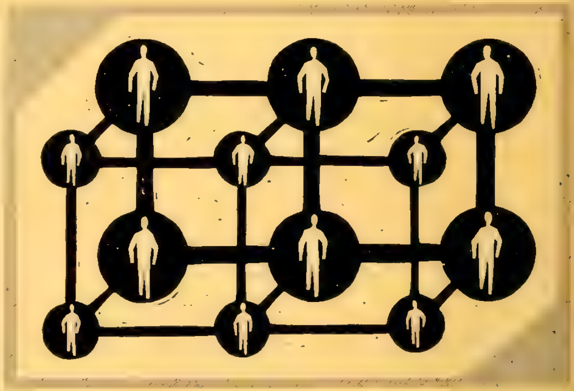
Monday, September 20

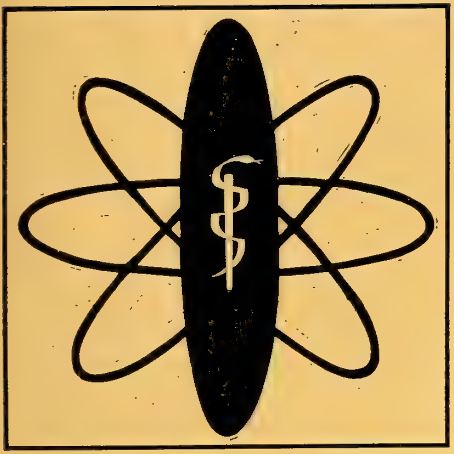
Medicine and Business, Industry and Communications Day

- House of Delegates will honor 23 representative corporations in Business, Industry and Communications at Morning Session
- Awards Luncheon; Austin Smith, M.D., of PMA, Speaker
- House of Delegates Reference Committees in Afternoon; Business and special address at Evening Session
- Woman's Auxiliary to MSMS Convention begins at Pontchartrain Hotel; Continues September 21-22

Tuesday, September 21 Medicine and Medical Organization Day

- Announcement of Michigan's Outstanding Physician by House of Delegates; Presentation also of 50-Year Club, Certificates of Commendation, other awards
- Exhibit-Opening-Ceremony at high noon
- Scientific Program begins, Clinical Demonstrations, Exhibits, Colored Television Program
- Century Luncheon; Speaker, Windham Davies, M.D., MP, England
- Elections, Rechartering of County Societies, etc., at Evening Session of House of Delegates with President-Elect of American Medical Association as Speaker





Wednesday, September 22

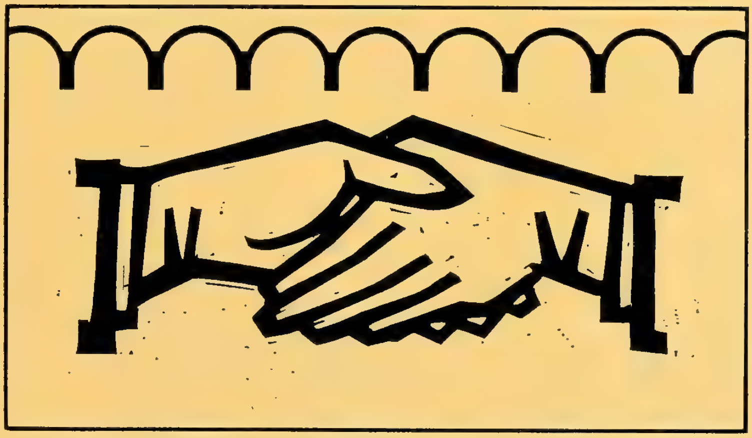
Medicine and Science Day

- Scientific Program continues with major assemblies, 5 Breakfast Clinical Discussions, 8 Scientific Luncheon Meetings; Colored TV, Exhibits, Clinical Demonstrations
- Special Meetings of Scientific Organizations
- Diet Therapy Conference
- National Health Careers Symposium
- Centennial Banquet; Speaker; Installation of New Officers
- Annual Convention of Michigan State Medical Assistants Society at Statler-Hilton. Continues Sept. 23.

Thursday, September 23

Medicine and Voluntary Health Day

- Scientific Program continues; 4 Breakfast Clinical Discussions; 4 Scientific Luncheon Meetings; Special General Assembly; TV, etc.
- Meeting simultaneously—4 national conferences: Health Careers, Financing Health Care, Smoking-Health, Nursing Homes; Profession and Public Invited
- All-Health Luncheon for 100 Voluntary Health Organizations and Michigan Health Council
- Special Tours to see Medical Art, Medical History, etc., at Detroit Cultural Center area
- Sponsored Reception and Dinner with Editor Jenkin Lloyd Jones; Fisher Theatre Party; Afterglo



Friday, September 24 Medicine and Government Day

MEDICINE AND GOVERNMENT

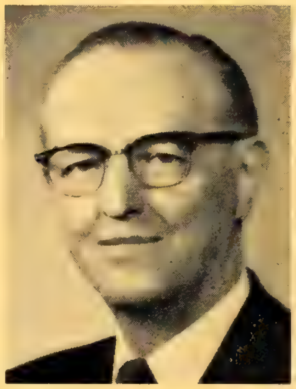
- Scientific Breakfast Meeting
- General Assembly on Preventive Medicine
- Governor's Luncheon with George Romney
- Awards to M.D.s outstanding in Public Service
- Public Invited to Afternoon Seminar on "Medicine's Role in Government and Government's Role in Medicine"; Five Speakers, including Congressman Durward Hall, M.D.

One of the speakers at the public Medicine and Religion Convocation, 2 p.m., Sunday, Sept. 19, at the Ford Auditorium, will be William G. Menninger, M.D., President of the Menninger Foundation, Topeka, Kansas. A world renowned humanitarian, he is a past president of the American Psychiatric Association.

Wm. G. Menninger, MD

The House of Delegates, Sunday night, Sept. 19, will hear the great American—Walter H. Judd, M.D., former Congressman from Minnesota. A former medical missionary to China, Doctor Judd is a national authority on foreign affairs.

Walter H. Judd, MD



The scientific program will begin Tuesday afternoon, Sept. 21, with a panel on "Endocrine Disturbances and Atherosclerosis." One of the panelists will be noted Thaddeus S. Danowski, M.D., Professor of Medicine at the University of Pittsburgh.

T. S. Danowski, MD

The general practice general assembly on Wednesday, Sept. 22, will include William T. Foley, M.D., of New York, as one of the speakers. Chief of the Vascular Clinic at the New York Hospital, he will discuss "The Immediate Treatment of the Acute Coronary."

Wm. T. Foley, MD

MORE THAN 125 SPEAKERS ON PROGRAM FOR CENTENNIAL, INCLUDING THESE AUTHORITIES:

Louis A. Orsini

One of the four simultaneous conferences on Thursday, Sept. 23, will deal with "New Approaches in Providing and Financing Health Care." Coming from New York to speak will be Louis A. Orsini, Director, Health Insurance Council of the United States.

Durward G. Hall, MD

The public Medicine and Government seminar on Friday afternoon, Sept. 24 will spotlight a panel including Durward G. Hall, M.D., Congressman from Missouri. The topic will be "Medicine's Role in Government and Government's Role in Medicine."

ANNOUNCEMENTS

Detailed timetable for House of Delegates, Sept. 19-20-21, will appear in August issue of MICHIGAN MEDICINE.

Official opening of scientific and technical exhibits in Cobo Hall, Tuesday noon. Thirty-two scientific displays and 127 technical exhibits are scheduled.

Breakfast Clinical Discussions will be held on Wednesday and Thursday mornings at Cobo Hall. Continental breakfasts will be served to small groups as they discuss problems with a panel of experts.

Clinical Demonstrations will take place in the Exhibit Area. Each morning and afternoon four different concurrent demonstrations will be presented by physicians in the Cobo exhibit area.

Hotel Reservations should be made as soon as possible. Blocks of rooms for MSMS members are being held at the Sheraton-Cadillac Hotel and the new Pontchartrain Hotel. Please mention that you will be attending the MSMS Centennial.

Registration for the House of Delegates will be at the Sheraton-Cadillac Hotel. Registration for members attending the scientific session and meeting will be at Cobo Hall. No registration fee for members or guests.

Category I credit for MAGP members.

Meeting of Woman's Auxiliary, Pontchartrain Hotel, September 20-21-22.

Meeting of Medical Assistants, Statler-Hilton Hotel, September 22-23.

MANY MICHIGAN PHYSICIANS SPEAK AT AMA CONVENTION

Many Michigan physicians were utilized as speakers at the recent AMA Convention in New York City.

(A report from the MSMS delegates to the AMA will appear in the August issue—because the deadline for the publication of this July issue was too early to permit inclusion of the story.)

The names of the scientific speakers, at the various meetings, are taken from JAMA.

M. H. Seevers, M.D., Ann Arbor, on "Experimental Studies in Dependence of Barbiturates and Amphetamines."

Calvin W. Woodruff, M.D., Ann Arbor, on "Nutritional Aspects of the Metabolism of Growth and Development."

Kenneth P. Mathews, M.D., Ann Arbor, on "Evaluation of Patients With Suspected Drug Allergy."

Funan Hu, M.D., Detroit, on "The Influence of Certain Hormones and Chemicals on Mammalian Pigment Cells."

Yutaka Mishima, M.D., Detroit, on "Cellular and Subcellular Differentiation of Melanin Phagocytosis and Synthesis of Lysosomal and Melanosomal Activity."

Edmund D. Lowney, M.D., Ann Arbor, on "Immunologic Unresponsiveness Following Percutaneous and Oral Exposure to Contact Sensitizers."

Gerald A. Lo Grippo, M.D., Bonnie R. Wolfram, M.D., both of Detroit, and Robert Jaslow, M.D., Northville, on "Effect of Infectious Hepatitis on the Immuno Globulins in Institutional Children."

Earl F. Wolfman, Jr., M.D., W. W. Coon, M.D., Ann Arbor, on "Sodium Retention Following Experimental Lesions of the Precommissural Septum in the Monkey."

Charles E. Lucas, M.D., Myron K. Denney, M.D., and Raymond C. Reed, M.D., Detroit, on "Hematochylia in Man and Animals."

Melvin A. Block, M.D., and Robert C. Horn, Jr., M.D., Detroit, "Elevated Blood Serotonin in Zollinger-Ellison Syndrome."

Robert Threlkeld, M.D., S. Newman, M.D.; E. M. Berkas, M.D., and A. P. Thal, M.D., all of Detroit, "Stomach Ulcer as a Complication of Jejunal Segment Interposition."

William R. Eyler, M.D., Detroit, on "Radioisotope Photoscanning of the Liver as an Aid in Differentiating Intra- and Extra-Hepatic Jaundice."

John R. Caldwell, M.D., Edward L. Moorhead, II, M.D., and Azorides R. Morales, M.D., all of Detroit, on "Pheochromocytoma: Diagnostic Clinical Features and Laboratory Correlations."

Rodman E. Taber, M.D., Ernest A. Hershey, M.D., and Conrad R. Lam, M.D., Detroit, on "Clinical Experience With a Vena Caval Clip for the Prevention of Pulmonary Emboli."

E. Osborne Coates, Jr., M.D., Detroit, on "Unusual Features of Chronic Obstructive Lung Disease in Women."

E. L. Quinn, M.D., Frank Cox, Jr., M.D., and E. H. Drake, M.D., both of Detroit, on "Staphylococcus Endocarditis."

Fred W. Whitehouse, M.D., Detroit, on "A Study of Diabetes Mellitus in Patients With Gout."

Walter P. Work, M.D., Ann Arbor, on "Therapy of Salivary Gland Tumors."

David G. Anderson, M.D., Ann Arbor, on "The Management of Advanced Endometrial Adenocarcinoma With Medroxyprogesterone Acetate."

Harold F. Falls, M.D., J. Reimer Wolters, M.D., both of Ann Arbor, on "Histological Study of a Monochromatic Eye and Psycho-Physiological Studies of the Fellow Eye."

Edwin M. Smith, M.D., Leonard F. Bender, M.D., both of Ann Arbor, on "Finger Flexors and Rheumatoid Metacarpophalangeal Deformity: Clinical Implications."

* * *

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Participants on Luncheon Round Tables, according to AMA Journal, were Conrad Lam, M.D., Detroit; George L. Waldbott, M.D., Detroit, and Walter P. Work, M.D., Ann Arbor.

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6 to 12 months–4 mg. (½ tsp. q.i.d.)
1 to 2 years–5 mg. (½ tsp. 5 times daily)
2 to 5 years–6 mg. (1 tsp. t.i.d.)
5 to 8 years–8 mg. (1 tsp. q.i.d.)
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2 tablets 4 times daily)
**Based on 4 cc. per teaspoonful.*

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AMA MEETINGS

1965—Clinical Meeting: Philadelphia, Nov. 28-Dec. 1
1966—Annual Meeting: Chicago, June 26-30
Clinical Meeting: Las Vegas, Nevada, Nov. 27-Dec. 3
1967—Annual Meeting: Atlantic City, June 18-22

Abstract of MSMS Council Action

Meeting of May 12, 1965

REVISED UNIFORM FEE SCHEDULE FOR GOVERNMENTAL WELFARE AGENCIES

The Council reaffirmed its previous decision that the Michigan Relative Value Scale be used as the basis for the revision of the Michigan Uniform Fee Schedule, last revised in 1959. It also decided that the conversion factor to be applied to the Michigan RVS should be related to current and customary fees. A $5.00 conversion factor representing 1964 current and customary fees was approved.

EMERGENCY CONFERENCE ON STATE HEALTH LEGISLATION

The Council noted the success of this special meeting and praised the physicians and staff who implemented the Conference recommendations and made effective contact regarding their views on proposed legislation in their home areas.

TEMPORARY EXPANSION OF LEGAL AFFAIRS STAFF

Temporary addition of one person to the legal affairs staff was authorized until the summer recess of the Michigan Legislature.

PRESENTATION OF AMA-ERF CHECKS

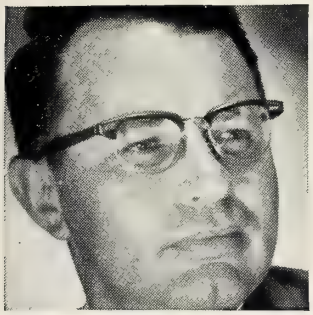
On behalf of MSMS members contributing to the American Medical Association Education and Research Foundation, The Council presented checks to the deans of the Wayne State University and University of Michigan medical schools. The Wayne check totaled $11,491, and the U-M check totaled $17,543. Plans for a public presentation over a Detroit television station were announced.

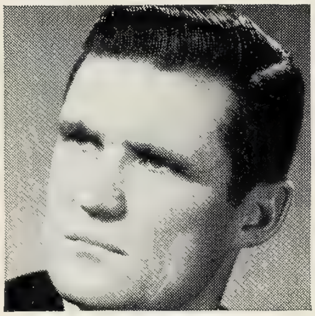
IMPLEMENTATION OF PROPOSED MEDICARE PROGRAM

The Council directed a letter to the American Medical Association presenting the MSMS position that medical organizations should be the units to bargain for benefits and services under Medicare if this legislation is adopted.

J. D. Brown—Detroit, Southwest

D. F. Hansen—Detroit, Northwest


P. J. McGrath—Flint-Pontiac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"MD's Collect Art" Show Set; Invite Exhibit Works Now

In observance of the MSMS Centennial Session, the Detroit Institute of Arts will sponsor an art show entitled "The Doctor Collects Art." This exhibit will be held at the beautiful Detroit Institute of Arts, located in Detroit's Cultural Center, and will be open during the entire Centennial Week—September 19-24.

This is not an exhibit of work by physicians, but rather of the work that they have collected. The annual art show of work by doctors and their wives will be held again by the Woman's Auxiliary to MSMS at Cobo Hall during the Centennial.

The Detroit Institute of Arts special show will include as many art objects as space permits. All fine arts, contemporary or traditional, will be considered—namely, paintings in all media, small sculptures, and graphics or prints in lithographs, serigraphs, woodcuts and etchings.

MSMS members are invited to submit, in writing, a description of one or more art objects they have collected, which they wish to be considered for exhibition.

Please include the following data: size, whether framed or unframed, title, artist's name and date of the work. Please do *not* forward the work of art itself. Selections will be made by the Detroit Institute of Arts from the descriptions. More than one work may be submitted for consideration. If the art object is selected for this show, the Detroit Institute of Arts will provide instructions about crating, insurance, etc.

Please send all pertinent details to:

Mr. Willis Woods, Director
Detroit Institute of Arts
5200 Woodward Avenue
Detroit 2, Michigan

MSMS REPRESENTED AT STATE MEDICAL MEETINGS IN MIDWEST

Many midwestern physicians have heard about the upcoming MSMS Centennial Session from MSMS officials as they made official visits to other state society conventions.

President Oliver B. McGillicuddy, M.D., visited both the State Medical Society of Wisconsin at Milwaukee and the Illinois State Medical Society annual meeting in Chicago; and President-Elect Luther R. Leader, M.D., was an honored guest at the Ohio Medical Association meeting in Columbus.

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DOCTORS WANTED FOR SMALL TOWNS

**By Robert E. Rice, M.D.
Chairman,
MSMS Rural Medical
Service Committee**

Of all the ranking problems concerned with the practice of medicine, probably the one of the moment is the "scientific neglect" treatment we have given to the problem of distribution of physicians to the smaller communities.

While the total number of medical graduates is reasonably adequate for all the phases of medicine, it is apparent that all but a small percentage shy away from small communities where, in fact, the need is greatest.

Factors having some influence on this problem include

(1) orientation in medical school toward specialty practice;
(2) types of facilities in smaller communities, and
(3) lack of effort by county societies and individual physicians.

Recently some medical schools have shown awareness of this situation and have taken steps to assume their part of the responsibility for its improvement. The University of Michigan Medical School is embarking on a "Family Practice Program" which involves the student through his training years, emphasizing general practice with some time spent in outlying hospitals. Some schools have engaged in preceptor plans of one sort or another. Others have participated in financial plans which carry some obligation to spend a certain time in community practice. These types of activities should tend to alleviate the situation somewhat.

Facilities in smaller communities differ greatly from the large teaching center or even the large urban hospital. This is as it should be. The smaller general hospital has a specific function of providing a wide range of care for most of the ills of the community. Many small communities have such a hospital or are near one. Only a small percentage of cases require transfer or refer to facilities capable of more complicated care.

* * *

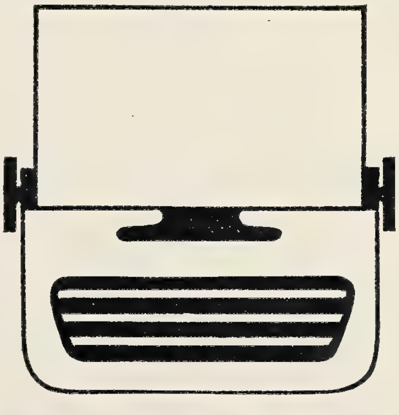
THIS FACT IS not readily appreciated by the young physician who feels that somehow he must be surrounded constantly by vast amounts of complicated equipment which the great majority of patients rarely need.

It is a fact of life that our failure to encourage young physicians to set up practice in small communities has left them without reasonable access to good medical care. Into this vacuum the osteopaths have been able to establish hospitals and offices of highly successful nature. Palatable or not, communities that were shunned as too small by young M.D. physicians now support several osteopaths and an osteopathic hospital.

Now, perhaps, we should consider the crux of this whole matter. It appears that a considerable part of the problem rests in the fact that, as individual physicians, we have not sought out and encouraged potential physicians that would be inclined to practice in small communities.

* * *

IT WOULD obviously enhance the efforts of the medical schools and the placement service of the Michigan Health Council if they could be dealing with a reasonable number of young physicians who consider community practice their *first* choice. The Rural Medical Service Committee has recommended that every physician and



EDITORIAL VIEWS

county society expend efforts to attract young men into the field of general practice.

Numerous activities along this line by physicians or county societies might include:

(1) Providing an honest appraisal of the value of general practice,

(2) Being alert to prospective medical students in the community,

(3) Working with high school counselors on medical careers,

(4) Participating in programs for PreMed clubs in colleges,

(5) Cooperating in career days in schools and communities,

(6) Making available or locating financial assistance when necessary.

(7) Inviting medical students and interns to observe community hospitals in action.

(8) Being familiar with and utilizing the placement service of the Michigan Health Council.

With a little imagination and effort we should be able to address ourselves to this problem with gratifying results.

Teen-Age Trouble

The primary and secondary syphilis case rate per 100,000 population in the State of Michigan for fiscal year 1964 was 6.3. Our cities varied with rates of 1.9 for Lansing, 3.0 for Grand Rapids, 7.5 for Flint, 10.0 for Saginaw, and 21.6 for Detroit. Many cities in other states, particularly in the South, had much higher rates and the highest of all was Newark at 114.

National statistics show that reported infectious syphilis cases continue to rise in the nation for the seventh consecutive year. The 22,733 infectious syphilis cases reported in 1964 were the greatest number reported since 1950. Reported gonorrhea victims increased from 270,076 cases in 1963 to 290,003 in 1964. An age breakdown of case rates shows that the infectious syphilis incidence rate in the 20-24 age group is 55.8 cases per 100,000 population, or 4½ times the national average of 11.9 cases per 100,000 population for all ages.

The rate among teen-agers is 22.8, or twice the nation's average for all ages, and these same ratios hold true with reference to gonorrhea, as well.

Some strains of gonorrhea are showing increased resistance to treatment with penicillin although such problems have not been noted with this agent in the treatment of syphilis.

In 1964, one out of every 81 marriage applicants was seriologically positive for syphilis in one stage or another and one out of every 99 prenatal blood tests of pregnant women indicated the presence of syphilis in one of its stages.

These figures were made available in a publication entitled, "Today's VD Control Problem," which is a joint statement from the Association of State and Territorial Health Officers, the American Venereal Disease Association, and the American Social Health Association. The report clearly emphasizes that the physician of today must maintain a constant awareness of venereal disease, particularly in young people.

A high priority must be given to appropriate training for medical students, interns and residents, in the diagnosis and management of venereal disease and programs of veneral disease education should be continued by civic and professional organizations along with support to the efforts of our state and local health officers in prevention and control.

Of Merck and Milestones

Probable lifelong immunity to measles as the result of a single dose of vaccine is in many ways similar to the dramatic announcement of the Salk vaccine for poliomyelitis. More than five million children in the United States have already been so immunized. An intensive MSMS supporting educational effort began last March.

What is not generally recognized is that Merck, Sharp and Dohme have furnished promotional materials and other assistance without the use of their name and entirely free of commercial overtones.

Once more, a pharmaceutical profession and the doctors of medicine have joined hands and another milestone has been passed in clinical preventive medicine.

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Voices for Economic Freedom

By C. T. Hardwick, Ph.D.
Economic Consultant to MSMS

ISSUES FOR AMERICA

On open, free society should be predisposed to listen to many voices, many writers, and many proposers if we are to remain free. In the political-economic arena, argument, debate and experiment are given factors if we aim for progress and improvement.

In the words of Edmund Burke, "All that is required for the triumph of evil is that good men remain silent and do nothing." Therefore, today voices for freedom must be heard.

At any particular time and place, some voices are more popular than others. Up to the 1930's, in America, the voices in favor of initiative, freedom, innovation, and private enterprise were popular and acceptable.

Then the crisis of a depression opened the door to a socio-economic revolution. Because of the emergency, voices of the reformers were welcomed and endorsed. Many ideas and philosophies of socialistic writers of Europe and England were embraced and adapted to the American scene under the titles of "New Deal" and "Fair Deal."

* * *

FOR 30 YEARS, the proponents of government support, regulation, control and public domination of socio-economic segment have been heard, endorsed, and often presented as the best solution to current problems. The depression is long gone, the second world war has been fought and won, peace and prosperity has become a norm but the old-fashioned, socio-economic ideas of economic freedom seem to be lost and forgotten in the promise of a "Great Society." This means the causes for the expansion of the public economy have disappeared, but the program of more and more government keeps up high steam in favor of public activities.

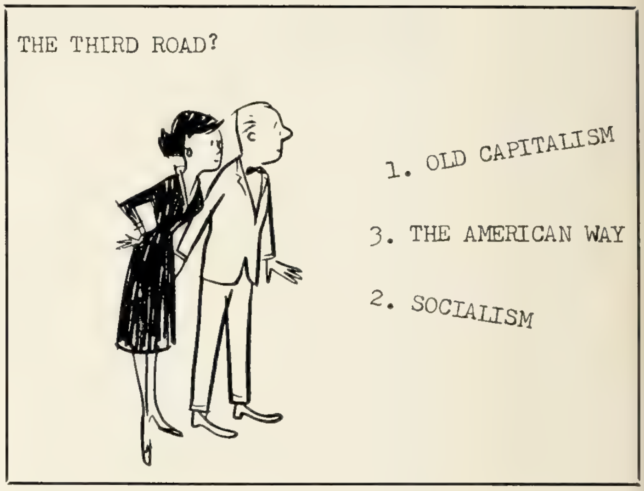
In keeping with the proposition of the opening paragraph of this article, it seems reasonable to inquire about the other voices speaking in behalf of the individual and free enterprise society which is also a heritage of Americans.

* * *

IN OTHER WORDS, where and who are the voices of the private sector speaking contrary to the welfare state proposers?

This article will briefly review some of the writers still speaking for self-reliance, private initiative, individual responsibility, private choice, independent action, voluntary co-operation and freedom of individual citizens and private groups.

Let us remember all citizens pay the tax bill of government enterprise and thus *All* should be heard in the debate to extend the public economy further into our lives which always means more taxes.



VOICES FAVORING FREEDOM

No rational person would deny the privilege and even the natural right of those who wish to speak and argue in favor of government intervention in the cases of abuse. At the same time, all reasonable persons should grant the same right to those who oppose government and favor individual and group freedoms.

Now, let us review some of the voices who are writing in favor of America's heritage of freedom to think, to speak, to organize their own socio-economic life.

At the University of Chicago, Professor Milton Friedman has presented his profession's views as an economist in a book called "Capitalism and Freedom." He explains the organization of modern economic activity through private enterprise. His contention is that *economic* freedom is necessary to preserve *political* freedom.

* * *

IN THE first part of the book, Professor Friedman discusses the principles of a liberal free society as well as outlining the essential but limited role of government. In general, government should be a rule maker and umpire not a playing manager. In a welfare state, somebody decides what people *ought* to have, whereas in a free marketplace people buy what they want or decide is personally preferred. Free men should be afraid of any force, especially do-good states, to make decisions for them.

After establishing a general frame of reference for private enterprise society, Professor Friedman then proceeds to examine some specific socio-economic issues, including; monetary economics, international trade, fiscal policy, labor relations, social security, and poverty.

In any of the specific chapters, some of us may disagree with Professor Friedman's details. For example, in the chapter on education, this author does not think he argued strong and long enough in favor of a "dual" system of private and public education. He does state the case for private education at university level, with some pertinent arguments, but weakens in the face of financial help from government.

* * *

FURTHERMORE, SOME physicians may not like what is said in chapter nine about the AMA as to its power and its actions.

However, in a free society, the basic freedom is to argue, to disagree, and to refute others' ideas. Professor Friedman states his position clearly with these words:

> "The aim of this analysis is not to decide these questions for the community but rather to clarify the issues involved in making a choice, in particular whether it is appropriate to make the choice on communal rather than individual basis."

Professor Friedman closes his book with the hopeful observation "that we shall be able to preserve and extend freedom" in spite of economic powers being concentrated in the hands of government if we persuade our fellow men that free institutions are worth preserving.

* * *

ANOTHER voice in favor of economic freedom is that of Professor Thomas A. Petit of Drury College, Missouri. In a book called "Freedom in the American Economy," Professor Petit traces the historical milestones of our freedom. He begins with our European heritage and shows its influence on American foundations. Of course, he analyzes the classical theory of capitalism and shows the modifications made during the pressures of the depression. Also, Professor Petit discusses the Keynesian Revolution in Economics which was an attack and reorientation of classical treatment with emphasis on employment and public policy with action.

In the concluding chapter, Professor Petit tries to explain in practical terms the challenge to retain our beliefs in freedom and to effect reasonable changes in our economic mechanisms and economic institutions. This, of course, is the core problem. How can we maintain a cultural ideal of freedom in a capitalistic economy in which government is

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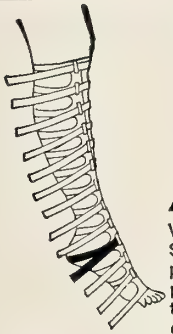

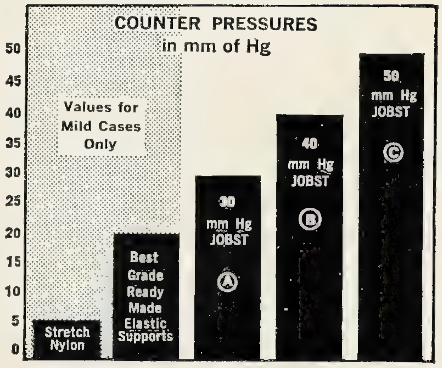

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becoming more and more dominant? Our institutions and organizations will undoubtedly change, but our eyes and voices must be concentrated on the goals of freedom.

* * *

PLANNING, decision making, freedom of choice must be retained to some major extent in the private segment, even if we accept a bigger role for government. One of the characteristics of American capitalism has been its ability to adapt to changing conditions. Professor Petit clearly says it: "If the American Way is to prevail, it is essential that we continue to have faith in our fundamental political and economic institutions."

AMERICA'S CHOICE—"The Third Road"

Of course there are other writers and speakers giving voice to the need to protect economic freedom. All are in the tradition of Dicey, Mises and Hayek. Just as Hayek spoke out in "The Road to Serfdom," they all fear the concentration of economic power in the hands of government. The welfare state aims to secure more *things* for more people, which is a very great temptation.

* * *

THE QUESTION being asked by the thinking but practical American appears to be: what choice do we have?

In an over-simplified way, we can choose to go along with the welfare state, which is a nice phrase for collectivism, or fight for freedom and private enterprise. Of course, the fight for modern private enterprise is not caught with unbridled freedom for the strong to abuse and exploit the weak. All Americans—businessmen, teachers, and other professionals—have developed a serious social consciousness to help and protect their fellow man. Professor Wilhelm Roepke, in his book entitled "Economics of the Free Society" used the phrase—The Third Road. This proposal permits a mixture of individualism and collectivism.

America in the mid-twentieth century is already on the "third road," which is sometimes called a "mixed economy"—partly public and partly private. The struggle during the remainder of this century will be to determine the kind and degree of mixture.

There is no doubt that abuses and ineffectiveness in the private sector during the thirties, forties, and fifties brought more and more government into the picture.

* * *

NOW THE QUESTION is how about listening to other voices to avoid the domination of big government in business, agriculture, education, and medicine.

We still have a choice.

Will Americans who believe in freedom fight hard enough to preserve it?

The answer lies within the heart of each of us.

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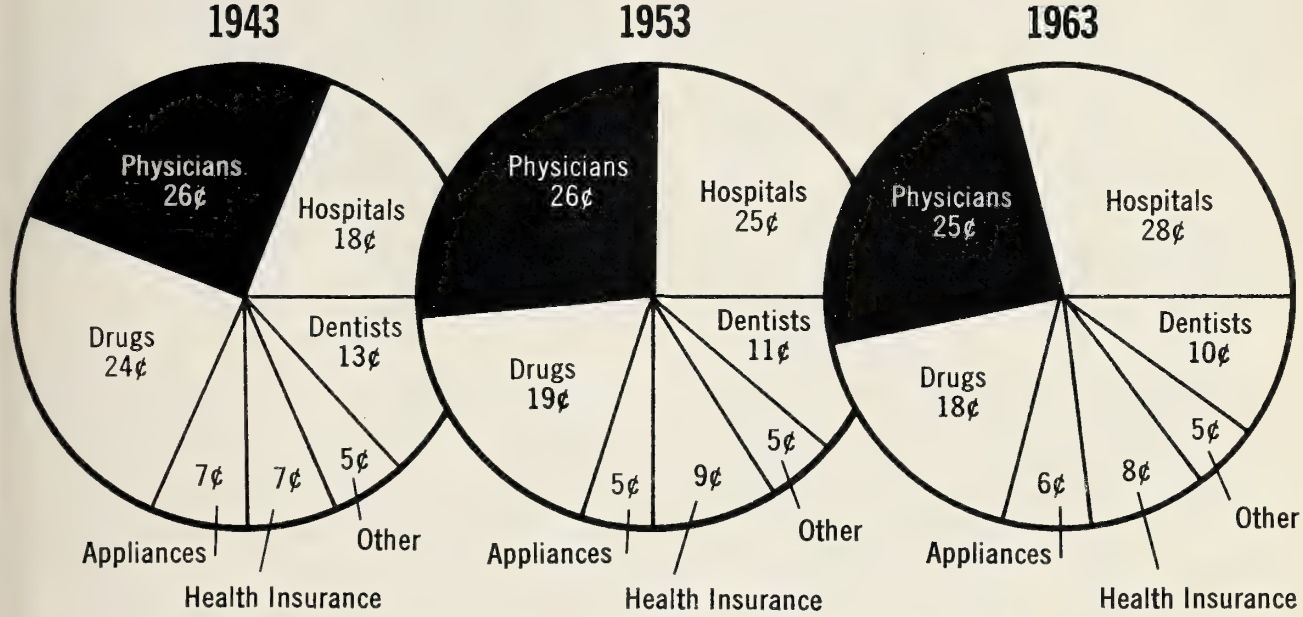


SOURCE: U. S. Dept. of Commerce

HOSPITAL SHARE OF HEALTH DOLLAR UP

Hospitals received the largest share of every health dollar spent by Americans in 1963, according to Department of Commerce figures on personal expenditures.

Twenty-eight cents of every health dollar went to hospitals, 25 cents went to doctors, 18 cents was spent on drugs, 10 cents was paid to dentists, 8 cents went for health care, 6 cents went for the purchase of appliances, and 5 cents was spent on all other services.

The doctors' share of payments for health care was up 1 per cent from 1962, but was down 1 per cent from the share received 10 years earlier.

An analysis of the 1963 statistics by the American Medical Association's Department of Medical Economics shows the nation's consumers spent $23.6 billion for health care in 1963, including $6.6 billion for hospital charges, $4.3 billion for drugs, and $5.9 billion for physicians' services.

Americans spent a total of $375 billion for their personal needs in 1963. About 6.3 per cent of this went for health care.

The major change in health care expenditures shown by the three pie graphs is the steady increase in hospital costs, from 18 cents of the dollar in 1943, to 25 cents in 1953 and now 28 cents in 1963. The share for drugs and dentists dropped slightly in each of the 10-year steps.

Social Security-Medicare Tax Schedule as Proposed

Here is how the annual Social Security-Medicare tax paid equally by both employers and employes would rise in eight stages over the next 21 years if the recently passed House Bill introduced by Representative Wilbur Mills becomes law.

	S.S. Rate	Med. Rate	Wage Base	Maximum
Now	3.625%	None	$4,800	$174.00
1966	4.0%	0.35%	5,600	243.60
1967	4.0%	0.50%	5,600	252.00
1969	4.4%	0.50%	5,600	274.40
1971	4.4%	0.50%	6,600	323.40
1973	4.8%	0.55%	6,600	353.10
1976	4.8%	0.60%	6,600	356.40
1980	4.8%	0.70%	6,600	363.00
1987	4.8%	0.80%	6,600	369.60

Here is how the annual Social Security-Medicare tax paid by self-employed persons would rise:

	S.S. Rate	Med. Rate	Wage Base	Maximum
Now	5.4%	none	$4,800	$259.20
1966	6.0%	0.35%	5,600	355.60
1967	6.0%	0.50%	5,600	364.00
1969	6.6%	0.50%	5,600	397.60
1971	6.6%	0.50%	6,600	468.60
1973	7.0%	0.55%	6,600	498.30
1976	7.0%	0.60%	6,600	501.60
1980	7.0%	0.70%	6,600	508.20
1987	7.0%	0.80%	6,600	514.80

COLLER BANQUET SPEAKERS SELECTED

Outstanding leaders in Michigan medicine will participate in the banquet program, July 29, at the 45th Annual Coller-Penberthy-Thirlby Medical Conference at Traverse City, July 29-30.

William N. Hubbard, Jr., M.D., Dean of the University of Michigan School of Medicine, will be toastmaster.

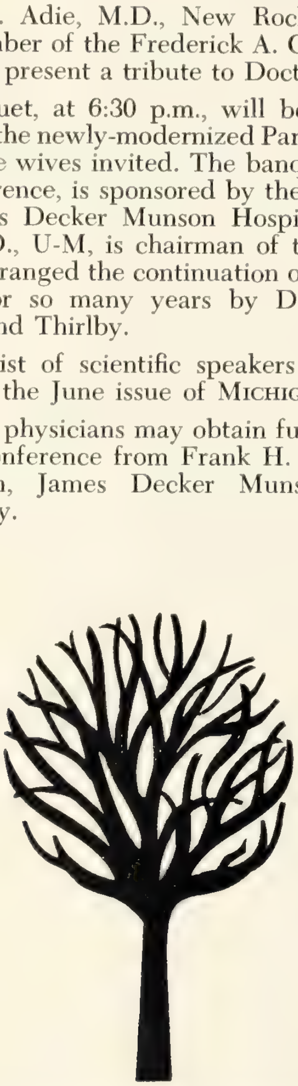
Remarks will be made by Gordon H. Scott, Ph.D., Wayne State University Vice-President for medical school development, A. C. Furstenberg, M.D., Emeritus Dean of the U-M School of Medicine; and Oliver B. McGillicuddy, M.D., MSMS President.

George C. Adie, M.D., New Rochelle, N.Y., a leading member of the Frederick A. Coller Surgical Society, will present a tribute to Doctor Coller.

The banquet, at 6:30 p.m., will be held in the ballroom of the newly-modernized Park Place Motor Inn, with the wives invited. The banquet, as in the entire conference, is sponsored by the medical staff of the James Decker Munson Hospital. A. James French, M.D., U-M, is chairman of the committee which has arranged the continuation of the program promoted for so many years by Doctors Coller, Penberthy and Thirlby.

The full list of scientific speakers and subjects appeared in the June issue of MICHIGAN MEDICINE.

Interested physicians may obtain full information about the conference from Frank H. Power, M.D., Co-Chairman, James Decker Munson Hospital, Traverse City.



ANCILLARY SECTION

AT DEDICATION

Conferring at the dedication of the WSU Medical Research Building were, from left to right— Richard Strichartz, Controller of the City of Detroit and former WSU professor; Gordon H. Scott, Ph.D., Vice President for medical school development; Ernest Gardner, M.D., Dean of the School of Medicine, and Alexander Walt, M.D., Assistant Dean and Chairman of the dedication committee.

WSU OPENS NEW RESEARCH BUILDING

"In the years to come, Detroit will earn another designation—the 'Medical City,' because Detroit will have the largest, most modern medical complex anywhere in the United States." This prophecy was made by Jerome P. Cavanagh, mayor of Detroit, in a speech delivered at the dedication of Wayne State University's Medical Research Building.

The $4 million structure at 550 East Canfield is the first new building to be completed in the 236-acre Detroit Medical Center. Future plans for the WSU School of Medicine campus in the center call for a new library, conference center, out-patient clinic, additional research buildings, parking structures and a new basic science building.

Other dedication speakers were: Francis Schmehl, M.D., of the National Institutes of Health, Retiring WSU President Clarence B. Hilberry, and Gordon H. Scott, Ph.D., WSU vice president for medical school development.

Medical research at Wayne State University is supported by more than $3 million in annual grants from local and national health agencies.

"The new research building provides long-needed expansion of existing facilities for the faculty at the present basic science building and for other members of our staff at 12 of the 16 institutions affiliated with the medical school," declared Ernest Gardner, M.D., dean of the WSU School of Medicine.

The building features such architectural innovations as a utility core enabling utility modifications without disturbing researchers, and a circulating corridor or "buffer" which controls the environment.

Approved Merit Rating Offers Greater Equity In Blue Shield Rates

A merit rating plan adopted by Michigan Medical Service (Blue Shield) on May 26, will provide greater equity in health care rates for all groups, according to Sidney Adler, M.D., Blue Shield president.

Merit rating was first proposed by Blue Shield in November, 1964. After two public hearings, it was approved by the State Insurance Commissioner on May 17.

The new rating procedure will begin after July 1, with new rates becoming effective on the anniversary date of the group contract. Thereafter, group rates will be adjusted once a year, if necessary, to reflect the cost of benefits used.

However, Doctor Adler emphasized that there will be no change in rates for senior citizens, non-group subscribers or group conversion subscribers who have left their groups because of retirement or other reasons.

Under merit rating, groups will be separated by size—under and over 150 contracts.

Rates for each group with 150 or more contracts will be influenced by the "experience" or frequency of use of benefits by group members. If a group has favorable experience, it will have lower rates. And, poor experience will result in higher rates.

Doctor Adler said that groups are protected from being priced out of the health care market by limiting rate increases to no more than 20 per cent from year to year.

Commenting on rating smaller groups, he said that groups with fewer than 150 contracts will be community rated. These smaller groups will have lower Blue Cross-Blue Shield rates.

Doctor Adler explained that merit rating has the following advantages to the medical profession:

Merit rating is expected to attract more people to Blue Cross-Blue Shield because of lower rates.

Merit rating is designed to create a greater solvency for Blue Shield.

Merit rating may permit expansion of the scope of benefits.

Most important, Doctor Adler said, merit rating offers Blue Shield and physicians an opportunity to expand their services and continue to provide the best medical care at the lowest possible price.

Aid Nursing Students

The Michigan League for Nursing has processed 666 applications for the 24 scholarships offered this year to Michigan high school graduates. The scholarships range from $400 to $2,000.

Radio Ad Applauds Service by Physicians

The advertising agency for Cunningham Drug Stores reports it has had "a number of excellent comments" in response to its once-a-week "salute to doctors" over WJR.

The advertising copy reads in part . . .

"Some of America's most highly respected and best known doctors are practicing tirelessly right here in Michigan. And for this we are thankful. Michigan's competent doctors are the leaders in the health field whose grave responsibility is the protection of man's most precious gift . . . his own life and that of his family's.

"Michigan's doctors have consistently met their responsibility with diligence and dedication. It is just such dedication that has resulted in Americans receiving the finest medical treatment in the world. Truly, Michigan's doctors have played a major part in making that statement a reality. Cunningham Drug Stores are proud to assist in a small part the over-all goal of modern medicine through filling precise and quality prescriptions just as the doctor ordered."

JAMA Article Gives Details On Goiter Survey in Tecumseh

"Goiter persists at an excessive frequency, especially among women over age 19 (15 per cent)." So stated Joseph Matovinovic, M.D.; Norman S. Hayner, M.D.; Frederick H. Epstein, M.D., and Marcus O. Kjelsberg, M.D., of the Medical School and the School of Public Health, University of Michigan, Ann Arbor, in a recent article in the AMA Journal.

The article discussed the U-M survey work at Tecumseh.

The survey of 8,641 persons in Tecumseh revealed thyroid enlargement in 451 females (10.2 per cent of those surveyed) and 124 males (2.0 per cent).

The authors declared that "In Tecumseh, only 62 per cent of salt purchased for human consumption during one winter month was iodized a level considerably below the reasonable goal of permanent and general goiter prophylaxis," the report said.

This doesn't mean 62 per cent of the people consumed iodized salt, the report said. Most probably consumed a mixture of iodized and non-iodized varieties. This was a level of iodine consumption too low for adequate goiter prevention, the report said.

The survey also suggested that iodine deficiency can have an adverse effect on mental development, as the average scholastic standing of goitrous children was lower than that of children with normal thyroid glands.

Tell Ways Cities Can Get Doctors

(See editorial about "Doctors for Small Communities.")

Medical, hospital and community leaders from more than 20 northern Michigan communities looking for one or more doctors of medicine attended a Health Day Conference at Big Rapids, May 19, co-sponsored by the Michigan Health Council and Ferris State College.

Principal speakers were Robert E. Rice, M.D., Greenville, Chairman of the MSMS Committee on Rural Medical Service and Chairman of the MHC M.D. Placement Committee; Norman C. Davis, Chicago, Director of Medical Program, Sears Roebuck Foundation; Bond L. Bible, Ph.D., Chicago, Secretary of the AMA Council on Rural Health; and Ralph T. Wills, East Lansing, MSMS Director of Community Relations. They discussed the broad efforts being made to acquaint family doctors and medical specialists with the opportunities in rural areas of Michigan and the United States.

Conference Co-chairman John A. Doherty, MHC Executive Secretary, reported that during the past five years there has been a gain of 736 M.D.'s licensed to practice in Michigan. The 30 northern counties have experienced a decline of three licensed doctors of medicine during the past five years.

A record number of 74 M.D. placements were made in 1964; however, there are still 135 Michigan communities registered with The Council that are looking for one or more general practitioners and there are more than 40 opportunities for medical specialists.

The speakers urged communities to (1) work together to encourage doctors to go into northern Michigan; (2) obtain advice from responsible sources before building medical facilities to attract doctors; (3) encourage more rural youths to consider medicine and give these youths the necessary financial assistance; and (4) make a community survey to determine whether the town actually needs a medical doctor or whether it would be more feasible to drive over modern highways to a larger neighboring community where, financially, better health care facilities could be provided.

Joseph Homminga, Lansing, Director of Hospital and Health Facilities Planning for the Michigan Department of Health, and Harry Parke, Lansing, Director of the newly organized Michigan Health Facilities Council, spoke briefly about the assistance that could be obtained from their organizations.

Doctor Bible said that he was "impressed with the sincere and cooperative interest of the state and community leaders who attended." He stated further, "On behalf of the AMA Council members, we want to thank you for the opportunity to participate in the program. Such meetings promote more effective communication with regard to the problems involved and the importance of community effort as well as the necessity for accurate information of community needs and resources. The AMA Council on Rural Health is particularly concerned with the problem of equitable physician distribution in rural as well as urban areas."

HELP OFFERED

Information about the Michigan M.D. Placement Service is given to participants at the Ferris State College Health Day Conference by John A. Doherty, standing, executive secretary of the Michigan Health Council. Other speakers (left to right) were Robert Huxol, FSC; Norman Davis, Chicago; Ralph T. Wills, MSMS; Robert E. Rice, M.D., Greenville, and Bond L. Bible, M.D., AMA. (Big Rapids Pioneer Photo.)

MSU, SPARROW HOSPITAL ENTER AGREEMENTS FOR TRAINING

The Sparrow Hospital of Lansing and Michigan State University will establish a 44-bed "University Service" which will be used to introduce MSU medical students to clinical medicine. The unit will be located in the hospital's new south wing now under construction.

The new agreement also provides for MSU to assume responsibility for the educational aspects of the hospital's intern and residency program.

MSMAS Plans UP Seminar

The Upper Peninsula Seminar of the Michigan State Medical Assistants Society will be held at the Northland Hotel, Marquette, July 17-18.

Harold Sponberg, president of Washburn University and president-to-be of Eastern Michigan University on July 1, will be the banquet speaker, July 17.

Miss Gwen Whitcomb, MSMAS vice-president, is chairman for the seminar.

MSMAS CONVENTION SET SEPT. 22-23

Early planning is advancing on schedule for the annual convention of the Michigan State Medical Assistants Society, in Detroit, September 22-23. The theme will be "A Year to Remember."

Miss Esther Bartlett, of Detroit, has been appointed general chairman by Miss Phyllis Marquardt, MSMAS president. Following are the other committee leaders, Reservation—Dolores Kobylka; Registration—Dolores Kobylka, Louise Rutila and Doris Woody; Publicity—Diane Dow; Door Prizes —Cora Steckel; and Decorations—Alyce MacQueston.

The convention as in the past will be held at the Statler-Hilton Hotel, but will take on added flavor and excitement this year because many events are being coordinated in the colorful plans for the MSMS Centennial Session.

The Desk Reference Cards on Rheumatic Fever have been updated and are available without charge. Eighteen topics including current views on valve surgery, prophylaxis and diagnosis are covered and indexed.

Write or call for a copy:

Michigan Heart Association
13100 Puritan
Detroit, Mich. 48227

"FOR THE GALS"

An attractive 24-page AMA booklet, "Winning Ways with Patients," is available without charge from MSMS for physicians interested in providing the booklet for their receptionists, secretaries and medical assistants.

The booklet suggests to these women that "You're a valuable gal in the doctor's office—he depends on you to practice the kind of public relations in his office that will make more friends for you, for him and for the medical profession as a whole." The copy deals with personality, ethics, scheduling, telephone courtesy and good business practices.

For a copy, write to MSMS, Box 152, East Lansing.

OFFER INDUSTRIAL HEALTH GUIDE

Copies of a new guide, "Personal Protective Equipment for Employees in Industry," may be obtained without charge from the AMA Department of Occupational Health, 535 North Dearborn Street, Chicago, Illinois 60610.

Produced and approved by the AMA Council on Occupational Health, this guide is intended primarily for those physicians who serve industry part-time or on-call, and to whom industrial employees come for preplacement, periodic examination, diagnosis or treatment.

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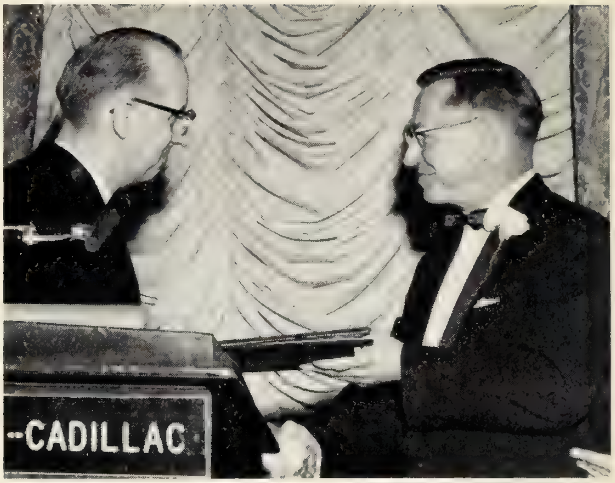
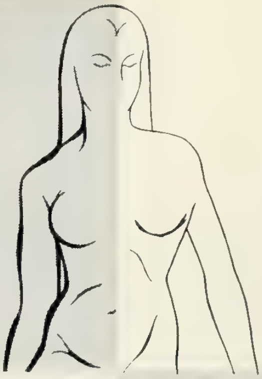


HONORED AT WSU

Gordon H. Scott, Ph.D., left, vice president for medical school development at Wayne State University, received a "Citation of Honor" from Hugh W. Henderson, M.D., outgoing president of the School of Medicine Alumni Association, at the 1965 Reunion Banquet. (Results of the Association election appeared in the June issue of Michigan Medicine.)

Don W. McLean, M.D., right, chairman of the Wayne State Fund board of directors, received a "Distinguished Service Citation" at the WSU Medical School Reunion. Here, Warren Nickel, M.D., offers congratulations to Doctor McLean, a past president of the Wayne County Medical Society and now a member of The MSMS Council.



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Tuberculin Test Added to School Checkpoint Law

By MICHIGAN DEPARTMENT OF HEALTH

On May 11, Governor Romney signed into law enrolled House Bill No. 280 (Public Act No. 29, 1965) which provides for tuberculin testing of school children entering Michigan schools. This adds a valuable tool to the fine immunization law which was already on the books.

Act 269 of the Public Acts of 1955, as amended by Act 12 of the Public Acts of 1960, requires that the parents of a child entering school in Michigan for the first time do one of three things:

1. Submit a statement signed by a physician that the child has been immunized against smallpox, diphtheria, tetanus, whooping cough, and poliomyelitis;
2. Sign a request to have the local health department give the necessary immunizations;
3. Sign a statement that they do not wish to have their child immunized.

This existing law, often referred to as the School Checkpoint Law, has been extremely helpful in securing protection of our pre-school children against the named diseases. The law as now amended does two additional things:

1. It adds the tuberculin test to the law, with the same three parental prerogatives as stated above; and
2. It provides that a record of immunization and tuberculin status be provided by school administrators to the State Health Commissioner through local health departments, where they exist, on forms to be provided by the State Health Commissioner.

In summary, the law compels no parent to do anything except think. It allows parents who object to immunizations, for any reason, to exempt themselves from the law (without, we believe, any significant effect on the public health). It will be important in improving both the prevention of disease in the children themselves and in enabling us to find additional persons with active tuberculosis in the families of the children so tested.

Infectious Hepatitis—Control in Schools

Recently there have been some inquiries regarding the control of infectious hepatitis in schools. Our general recommendations are as follows:

1. School nurses and teachers should be instructed about the early signs and symptoms of hepatitis in children.
2. Closing of schools has not been found to be effective in the control of communicable diseases. Children in the classroom are under closer surveillance and teachers should be on the lookout for sick children. As a general rule, in epidemic situations all children suspected of being ill should be excluded from classes and should be seen by the family physician. All proved cases of hepatitis should be excluded from school as long as they are symptomatic.
3. Teachers should organize energetic personal cleanliness campaigns. Children should wash their hands, under supervision, when arriving in school, after each toilet use, and before meals.
4. Workers in the school cafeteria should be carefully watched for signs of illness and, when such signs are apparent, should be excluded from their jobs. Sanitary procedures for handling food and utensils should be reviewed, and the importance of personal cleanliness, with particular emphasis on handwashing, should be stressed. It is usually wise to review some of the salient features of the disease with the workers so that they understand the problem.

In regard to books which have been used by, or in the possession of, an acute case of infectious hepatitis, the U.S. Public Health Service in their booklet "Viral Hepatitis" make no special recommendations for disinfecting books. However, a recent survey of bacteriologists and specialists in the field of public health revealed a unanimity of opinion that fomites, such as books and other inanimate articles, play a very insignificant role in the spread of communicable diseases. The replies all indicated that this hazard has been over-rated, and that there exists little or no direct evidence of actual spread of disease from books or other fomites.

Gamma globulin is not provided by the Michigan Department of Health for prophylaxis of classroom contacts, but only for household contacts of an acute case.

AT WORKSHOP

Representatives of 37 Michigan volunteer organizations at the recent Michigan Youth Commission Legislative Workshop heard Eleanor Skufis, M.D., Adrian. Doctor Skufis, who recently resigned as Lenawee County health director, discussed proposals to improve and broaden the services of county health departments. She is a member of the MYC.

COMMUNITY HEALTH WEEK PLANNING IS STARTED; '64 PRAISED

The AMA has an excellent publication, *PR Doctor,* which proposes an interesting challenge for the many county and state medical societies suggesting "How to Surpass '64 in '65" as far as the Community Health Week project is concerned.

MSMS obviously is interested in conducting a bigger-and-better Community Health Week, November 7-13, but . . .

The publication may not be too helpful for MSMS—because it singles out the 1964 Michigan activities as among the best in the nation!

So the many local leaders in the 1964 Community Health Week events in Michigan and the state officers of MSMS, the Michigan Health Council and the Michigan Association of the Professions can take a bow. Take a big bow!

The following are excerpts from the article in *PR Doctor,* which is mailed across the nation to leaders of county and state medical associations:

> "One of the most comprehensive programs of this type was carried out on a carefully-coordinated statewide basis in communities throughout Michigan. The Michigan Health Council, in cooperation with the Michigan State Medical Society and the Michigan Association of the Professions, took the leadership role in planning local observances.
>
> "Backed strongly by news and other promotional media, programs conducted encompassed many areas of community health. While the primary accent was on familiarizing Michigan residents with their health resources and needs, these programs also urged citizens to: secure a family doctor; obtain available immunization cards; avoid quacks and quack products, and encourage youngsters to enter the health professions.
>
> "Open houses were held in hospitals, rehabilitation institutions, nursing homes and at other medical facilities. Special emphasis was placed on physical therapy and careers involving rehabilitation. Eighteen physicians served as area Health Week chairmen and representatives of various health organizations served as "Teammates" in program planning. In all, approximately 200 health organizations, professions and voluntary agencies participated."

While you're reading these three lines, the U. S. government will have spent $110,000—*if* you're a fast reader.—Marshalltown, Iowa, *Times-Republican*

Measles Immunization Now Recommended by Academy of Pediatrics

The MSMS educational efforts to urge parents to have their children vaccinated against measles has picked up added support from an endorsement of the American Academy of Pediatrics. The Academy contends that "vaccines are safe and effective . . . and measles can be the next infectious disease to be eliminated from the United States."

The Academy—joining MSMS in its promotional efforts—urges "all physicians and public health personnel to take whatever steps are necessary to see that all susceptible children receive measles vaccine."

The elimination of measles by 1970 was seen by the Academy as a reality. The Academy recommended that "measles vaccine should be administered routinely to all children without a history of clinical measles or measles vaccination." The Academy did not recommend mass community immunization programs.

MICHIGAN M.D. AUTHORS

H. G. Bryan, M.D., and **R. K. Nixon, M.D.,** Detroit, "Dyskeratosis Congenita and Familial Pancytopenia," *Journal American Medical Association,* Vol. 192, No. 3, April 19, 1965.

Josip Matovinovic, M.D., N. S. Hayner, M.D., F. H. Epstein, M.D., and **M. O. Kjelsberg, Ph.D.,** Ann Arbor, "Thyroid Diseases in Tecumseh, Michigan," Vol. 192, No. 3, April 19, 1965.

C. Eugene Woodruff, M.D., and **Wilbur J. Steininger, M.D.,** Northville, "Intrathoracic Squamous Cell Carcinoma, Central and Peripheral," *American Review of Respiratory Diseases,* Vol. 91, No. 3, March 1965.

Conrad L. Giles, M.D., Southfield, "Treatment of Toxoplasma Uveitis," *American Journal of Ophthalmology,* October 1964.

R. M. Naibandian, M.D., I. J. Mader, M.D., J. L. Barrett, M.D., J. F. Pearce, M.D., and **E. C Rupp, M.D.,** Royal Oak, "Skin Changes from Coumarin Congeners," *Journal American Medical Association,* Vol. 192, No. 7, May 17, 1965.

R. C. Schneider, M.D., and **B. E. Antine, M.D.,** Ann Arbor, "Visual-Field Impairment from Football Gear," *Journal American Medical Association,* Vol. 192, No. 7, May 17, 1965.

John Grekin, M.D., and **Oscar D. Schwartz, M.D.,** Detroit, "Multiple Cutaneous Leiomyoma in Identical Twins", *Archives of Dermatology,* July 1964.

COUNTY SOCIETIES

Ottawa Aids Two Projects

The Ottawa County Medical Society has split the proceeds of its oral polio vaccine project to the county polio chapter and the mental health program. Checks for $6,085.32 have been presented to each of the two community health activities.

Huron Gives Therapy Equipment

Proceeds from the "Operation Sugar Cube" project in Huron County have been given by the Huron County Medical Society for additional physical therapy equipment for the Huron Community Health Center. The equipment in the Physical Therapy Department of the Health Center is available to all residents in need for such health care.

Jackson Pushes Careers

Once again, seniors of Jackson County high schools toured the Foote Hospital there as part of the career program sponsored by the Jackson County Medical Society. Robert E. Medlar, M.D., arranged the program.

Barry Funds Help Hospital

The Barry County Medical Society has donated the surplus funds from the oral polio vaccine clinics to the Pennock Hospital for three specific projects. The funds are to be used for the purchase of audio-visual equipment for the new Education Room; for special equipment for a room in the new emergency suite, and for special lighting in the emergency suite.

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Urges Liaison With Women's Organizations

By Elizabeth Margulis
AMA Field Service Staff

There are many reasons why medical societies should cooperate with women's organizations besides the Auxiliary.

Let me discuss several.

Every one of these millions of volunteer members is an opinion molder, at least in her own family, and an adult, therefore a potential voter. As the executive of a voters' association reminded us, right in their hands this minute is a political weapon of deadly potentiality—the women's organizations with more than 20 million members. Suppose crafty leaders should turn them into a militant political arm.

* * *

THESE ORGANIZATIONS banded together could seize all the political power in America within 15 years! (There *is* safeguard in the fact that it's unlikely that 20 million women could agree on any one thing).

Perhaps the greatest potential of all lies in the regular meetings where there are programs, a captive situation where women will listen, and where there is an unexcelled opportunity to present an educational program. This is an age when the need for continuing education, formal and not so formal, is widely urged from kindergarten to the grave.

Even professional educators agree that organization programs constitute the largest adult education opportunity in the country. When, during nearly every meeting, the president "turns the meeting over to the program chairman" the education begins. And the education provided can be about early American silver, or Navajo sand paintings, or American foreign policy,—or about some medical health subject. (These latter subjects are among the most popular, of course).

PUBLIC RELATIONS

* * *

WOMEN'S ORGANIZATIONS have another potential which results from their positive genius for raising money through projects. However, frequently they are so much in love with the process and with their ingenious projects that they fail to see that money-raising projects can also serve as public education. A little more publicity about the cause for which they work will turn the trick.

I have three suggestions to help a medical society to establish liaison with women's organizations:

1. Continue to show your concern for community health and welfare by all the things you do now. Show your dedication to your patients as you do now, and participate in civic affairs as you have time for them, but do it in such a way that you indicate interest in and availability to help promote worthy projects.
2. Set up your speaker's bureau, and send a description of the service, speakers and topics available to the women's organizations, as well as men's civic clubs. Try to offer speakers on a wide range of medical and health subjects so that there will be something of popular interest among them and that will relate the advances in medical practice to the public health.
3. This last should be first in my opinion. Use your built-in public relations agent, your own wife, to keep you abreast of what is taking place in these organizations. Urge her to join the Auxiliary first, then other organizations that interest her. Persuade her to consider herself the interpreter of medicine, its progress and its point of view, as well as a member of the organization.

* * *

WOMEN'S ORGANIZATIONS, along with the public in general, are interested in health, and they are actively promoting projects and programs in health education whether the medical profession, organized or as individuals, is concerned with their quality or not. I urge you to be concerned. The women will be *so* grateful.

Welcome, New Members

Russell A. Allen, M.D., 415 W. Maumee Street, Adrian, Michigan

Melvin L. Edwards, Jr., M.D., 1521 Hatcher Crescent, Ann Arbor, Michigan *(Internal Medicine)*

Charles F. Frey, M.D., 1412 Russell Road, Ann Arbor, Michigan *(Surgery)*

Donald M. Garland, M.D., 1531 Hatcher Crescent, Ann Arbor, Michigan *(Industrial Practice)*

Ronald G. Hines, M.D., St. Mary's Hospital, Saginaw, Michigan *(Pathology)*

Phillip A. Hoskins, M.D., 824 Edgewood Place, Ann Arbor, Michigan *(Roentgenology and Radiology)*

G. T. Johnson, M.D., VA Hospital, Saginaw, Michigan

James D. Klover, M.D., Central Michigan Community Hospital, Mt. Pleasant, Michigan *(Radiology)*

Jon L. Konzen, M.D., 815 Starwick Drive, Ann Arbor, Michigan *(Industrial Practice)*

Billie Lewis, M.D., 739 Mott Foundation Bldg., Flint, Michigan *(Surgery)*

Robert Packer, M.D., Detroit Receiving Hospital, Detroit, Michigan

Alan A. Reidinger, M.D., 700 Borton Street, Essexville, Michigan

Jose Ribeilima, M.D., 1840 Wealthy Street, S.E., Grand Rapids, Michigan 49506 *(Cardiovascular Surgery)*

John A. Rupke, M.D., 324 Forest Hill Avenue, S.E., Grand Rapids, Michigan 49506 *(Surgery)*

Howard J. Sawyer, M.D., 21971 Sloman, Oak Park, Michigan 48237 *(Industrial Practice)*

Amos Taylor, III, M.D., 301 East Kirby, Detroit 2, Michigan

Roberto I. Valdesuso, M.D., 14763 Rossini Drive, Detroit 5, Michigan

Praphuande Vanasupa, M.D., 1411 Center Avenue, Bay City, Michigan

Raymond W. Waggoner, Jr., M.D., 1421 Barnard, Ann Arbor, Michigan

Charles Adams, M.D., 2909 East Grand River Suite 104, Lansing, Michigan *(Thoracic Surgery and General Surgery)*

Charles Wang, M.D., 14 East 25th Street, Holland, Michigan

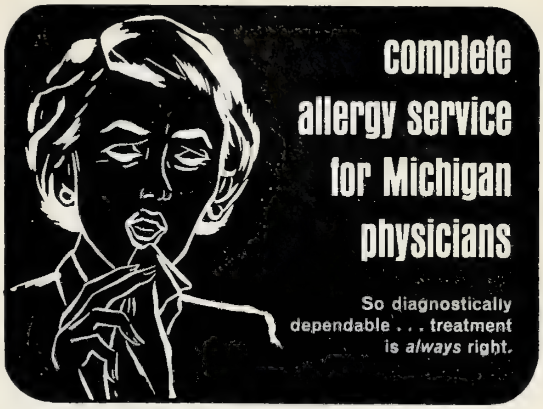
Aaron K. Warren, M.D., 109 School Street, Cassopolis, Michigan

John G. Wiegenstein, M.D., 2107 Aurelius Road, Holt, Michigan *(General Practice)*

J. C. Wohlrabe, M.D., Medical Arts Center, Muskegon, Michigan *(Psychiatry)*

David B. Youel, M.D., 45½ Seminole Street Pontiac, Michigan

Donald G. Young, M.D., 100 Michigan Street N.E., Grand Rapids, Michigan 49503 *(Pathology)*



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IN MEMORIAM

JOHN J. ANGEL, M.D.

John J. Angel, M.D., 56, died May 16, at Annapolis Hospital in Wayne where he was on the staff.

A 1936 graduate of the University of Michigan School of Medicine, Doctor Angel was engaged in general practice in Wayne. Doctor Angel was also a staff member of the Beyer Memorial Hospital in Ypsilanti.

CARL C. BIRKELO, M.D.

Carl C. Birkelo, M.D., 77, retired Detroit radiologist, died May 30 at Rochester, Minnesota.

Doctor Birkelo was graduated from the University of Chicago Medical School in 1914 and was radiologist at Herman Kiefer Hospital from 1920 until his retirement in 1956, at which time he moved to Winter Park, Florida. Doctor Birkelo also had been associated with the Detroit Public Health Department.

A World War I veteran, Doctor Birkelo was a member of the Radiological Society of North America, the American College of Radiology and the Detroit Roentgen Ray Society. His survivors include a son, Carl H. Birkelo, M.D., of Clarkston.

In 1964 Doctor Birkelo was granted the 50-Year Award from the Michigan State Medical Society and was a Retired Member.

ALLAN W. MULLIGAN, M.D.

Allan W. Mulligan, M.D., 70, ear, nose and throat specialist and plastic surgeon of Muskegon, died May 19 at Hackley Hospital.

A native of Sault Ste. Marie, Doctor Mulligan received his medical degree from the University of Nebraska College of Medicine. Doctor Mulligan interned at Blodgett Memorial Hospital, Grand Rapids, and was assistant to Doctor Ferris Smith there from 1922 to 1925. He then moved to Muskegon and practiced there for more than 40 years. He retired from active practice in 1958.

Doctor Mulligan was a member of the staff of Hackley, Mercy and Blodgett Hospitals. Among the survivors are Harold R. Mulligan, M.D., of Hollywood, California, and Arthur M. Mulligan, M.D., of Brainerd, Minnesota, brothers of Doctor Mulligan.

Doctor Mulligan was a Retired Member of the Michigan State Medical Society.

MORRIS RASKIN, M.D.

Morris Raskin, M.D., 55, a Detroit physician since 1934, died June 11, in Plymouth General Hospital, where he was chief of staff.

Born in Detroit and a graduate of Wayne State University School of Medicine, Doctor Raskin was medical director of Lakeside Medical Center. In

1946, Doctor Raskin organized the United Auto Workers union health center and served as its first medical director.

He had served as a member of the MSMS Legal Affairs Committee since 1962 and served his county medical society as a member of its Public Affairs Committee.

JESSE G. SLAUGENHAUPT, M.D.

Jesse G. Slaugenhaupt, M.D., 79, retired urologist of Detroit, died May 14.

Born in Manhattan, Kansas, Doctor Slaugenhaupt received his medical degree from the Chicago College of Medicine and Surgery in 1914. He was a member of the American Urological Association.

In 1964 Doctor Slaugenhaupt received the Michigan State Medical Society Award for having practiced medicine for 50 years. He was a Life Member of MSMS.

PERCIVAL C. STRAUSS, M.D.

Percival C. Strauss, M.D., 68, Lansing physician, died May 30.

A 1922 graduate of the University of Michigan School of Medicine, Doctor Strauss was physician for the city of Lansing from 1924 to 1927. In 1927 Doctor Strauss began the general practice of medicine and continued until 1958 when he became a medical consultant to the Disability Determination Service Program of the Michigan Department of Public Instruction Division of Vocational Rehabilitation. He was affiliated with Sparrow and St. Lawrence Hospitals of Lansing.

Doctor Strauss was a member of the American Academy of General Practice.

UDO JULIUS WILE, M.D.

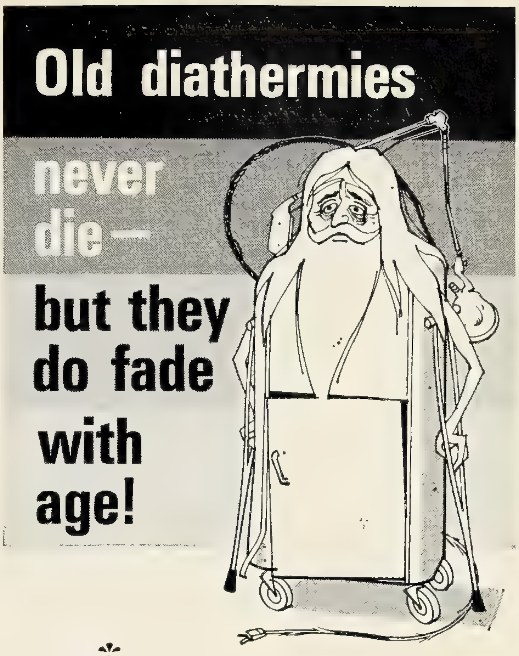
Udo Julius Wile, M.D., 82, one of the nation's most distinguished dermatologists, died June 7, 1965, in Ann Arbor.

Born in New York City, Doctor Wile received his medical degree from Johns Hopkins University School of Medicine in 1908. He practiced in New York until 1912, when he became chairman of the University of Michigan department of dermatology and syphilology, a post he held until his retirement as professor emeritus in 1945.

During his service at the University of Michigan, Doctor Wile established the nation's first university hospital clinic for specialists in skin diseases. From 1931 to 1936, when the U-M Medical School was without a dean, Doctor Wile and three other professors directed its operations.

Following his retirement in 1946, Doctor Wile continued his private practice in Ann Arbor until a year ago.

Doctor Wile was a former president of the American Dermatological Association and an honorary member of similar societies in France, Britain, Denmark, Hungary, Italy and Argentina. His other professional memberships included the American Board of Dermatology, the American Academy of Dermatology and Syphilology and the American College of Physicians. Doctor Wile was known for



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During World War I, Doctor Wile served as a major in Belgium and England, directing a military hospital in Liverpool. In World War II, as a colonel, he was chief medical director of the U.S. Public Health Service and was a consultant at a training and treatment center for venereal diseases. Following World War II, he was made a commander in the Ordre de la Sante Publique, a decoration bestowed earlier only on Sir Alexander Fleming and one other person.

Doctor Wile's survivors include a son, David Everett Wile, M.D., San Diego.

Doctor Wile was a Life Member of the Michigan State Medical Society.

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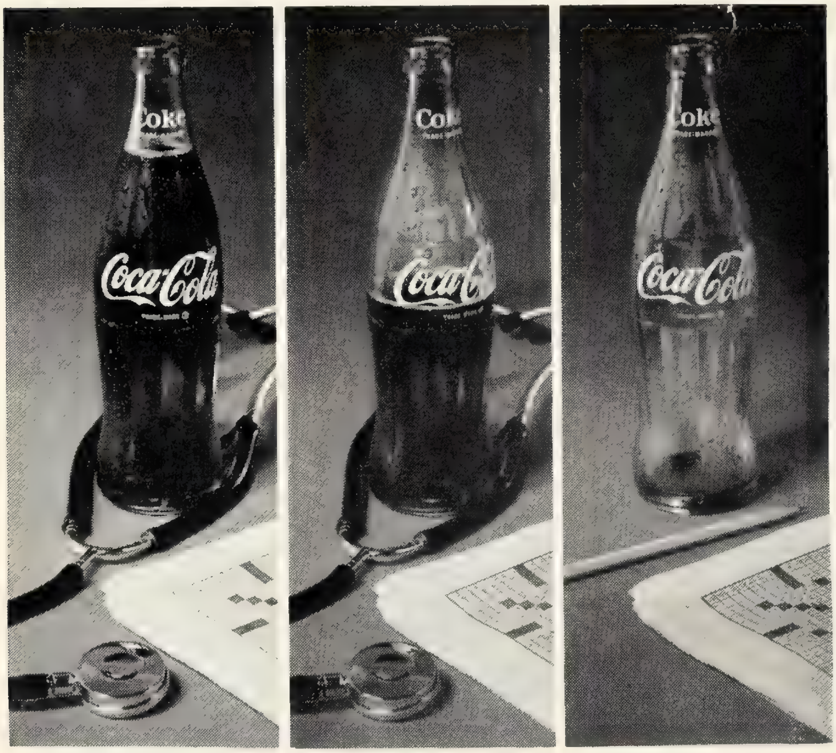

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STAFF PHYSICIAN (Michigan Civil Service V Level Position). Immediate vacancies for Staff Physicians at the Southwestern Michigan Tuberculosis Sanatorium, Kalamazoo, Michigan. 200-bed hospital. Salary range $14,365 to $17,539 annually. All Michigan civil service benefits, including an outstanding state contributory insurance program, excellent retirement plan, longevity bonus, and liberal vacation and sick-leave allowance. Should be a citizen of the United States. Must have two years of experience in the practice of medicine and surgery and have or be able to obtain a license to practice medicine in Michigan. Contact Winona Barrows, M.D., Superintendent and Medical Director, Southwestern Michigan Tuberculosis Sanatorium, 1500 Blakeslee Street, Kalamazoo, Michigan. Telephone: FI 5-5171. An equal opportunity employer.

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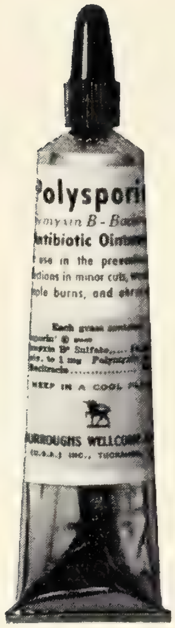

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Reporting As Ordered

A MONTHLY COMMENTARY

By Hugh W. Brenneman

EXECUTIVE DIRECTOR

"Complexus" should be the name of the MSMS headquarters.

Medicine touches upon every physical science; the practice of medicine upon every social science. Add to these the professional aspects of medicine; stir well, and you have the MSMS and its scientific interests.

The MSMS has business interests. It buys a half million dollars worth of materials and services each year: it sells and leases space in the amount of a hundred thousand. In this spending and selling, the MSMS influences the use of billions of dollars each year. **Is it any wonder** that medical organization which is supposed to merge these factors together is complex?

MSMS Interested In All Sciences

Participating as an integral part of medical science are the anatomists, biochemists, biophysicists, microbiologists, bacteriologists, mycologists, pharmacologists, chemists, etc., etc. Their relationships appear in MSMS liaison committees, in MSMS postgraduate education schedules, in MSMS disease control programs.

MSMS gets equally involved, sometimes perforce, with the social scientists—from the guidance psychologists in our student recruitment programs to the medical social workers in the home care system, to hospital administrators.

MSMS Relates To Many Vocations

Just to list the vocationalists—from the audiologists to the dietitians to the prosthetists, to the medical assistants, etc., etc., would take all of this precious space—but MSMS has some program related **to each of them.**

When we talk of business we must refer to MSMS relationships with prepaid medical and hospital care plans (Blue Shield and Blue Cross), with health insurance groups (Health Insurance Council), suppliers (MSMS exhibitors) and any number of associations through the Michigan Health Council.

The professional side of medical practice involves relationships of MSMS through the Michigan Association of the Professions and many liaison committees with specialists or other professional groups for special purpose projects.

Legislative Proposals Demand Attention

It seems almost unnecessary to point to the close contact your State Society must keep with legislative proposals **running the gamut** from health-giving techniques to hell-provoking taxation.

It is simply impossible to list the factors and the organizations your State Society deals with on complex matters of great import. Many of its decisions carry the weight of life itself for many people.

Just seeking to obtain the will of the officers and committees of this complex organization and **expedite their decisions** takes expert service. Last year, and this year to an even greater extent, broad subject areas have been placed under specific members of the senior staff somewhat as follows:

MSMS Staff Deals In Special Areas

Warren Tryloff, as Associate Executive Director, assists the general functioning of The Council and the MSMS committees, plus the technical and scientific exhibition and special assignments.

Morris A. "Mike" Riley—Governmental affairs including legislative contact. Also active in this area and in many advisory capacities involving law is Legal Counsel Lester P. Dodd.

Herbert Auer — Publications, publicity, education. As its managing editor he shares responsibility for MICHIGAN MEDICINE with Scientific Editor C. J. Tupper, M.D.

E. Ray Scott—MSMS office in Wayne County plus selected legislative and public relations functions.

Ralph Wills—Community relations, religion and political liaison.

Richard Campau — Economics and committees related thereto, guided by Economic Counsel Clyde T. Hardwick.

Robert Roney—Controller, membership, and production.

Helen Schulte—Scientific committees and special conference planning.

Personnel, planning within fiscal responsibility, and over-all supervision remain the inescapable responsibility of the Executive Director.

First Anniversary For Michigan Medicine

One year ago, the new "Michigan Medicine" made its debut in an effort to "more effectively serve each MSMS member and to improve the health of the general public."

The July, 1964, issue featured the new name for the journal of the Michigan State Medical Society, new cover, new features, new headlines styles, new type face for the articles, etc. There were 14 specific changes—and several more have been made since then.

Perhaps the greatest comment has been about the four center pages of "hot news" on colored paper. While the deadline was June 1 for the July issue, the deadline for the center insert was June 18. Members seem to appreciate this added effort to get news to them while it is current and pertinent.

The MSMS Council and Officers, the Publication Committee, the Scientific Editor and the MSMS staff will continue to welcome your suggestions and comments to improve —even further—the quality of Michigan Medicine.

MICHIGAN MEDICINE

the journal of the michigan state medical society

August 1965 • Vol. 64 • No. 8

Symptomatic Control Of Cough in Respiratory Allergies

Editorial: Meaning Of Merit Rating

DAILY THEMES FOR CENTENNIAL SESSION SEPTEMBER 19-24—DETROIT

Sept. 19—Medicine and Religion Day

Sept. 20—Medicine and Business, Industry and Communications Day

Sept. 21—Medicine and Medical Organization Day

Sept. 22—Medicine and Science Day

Sept. 23—Medicine and Voluntary Health Day

Sept. 24—Medicine and Government Day

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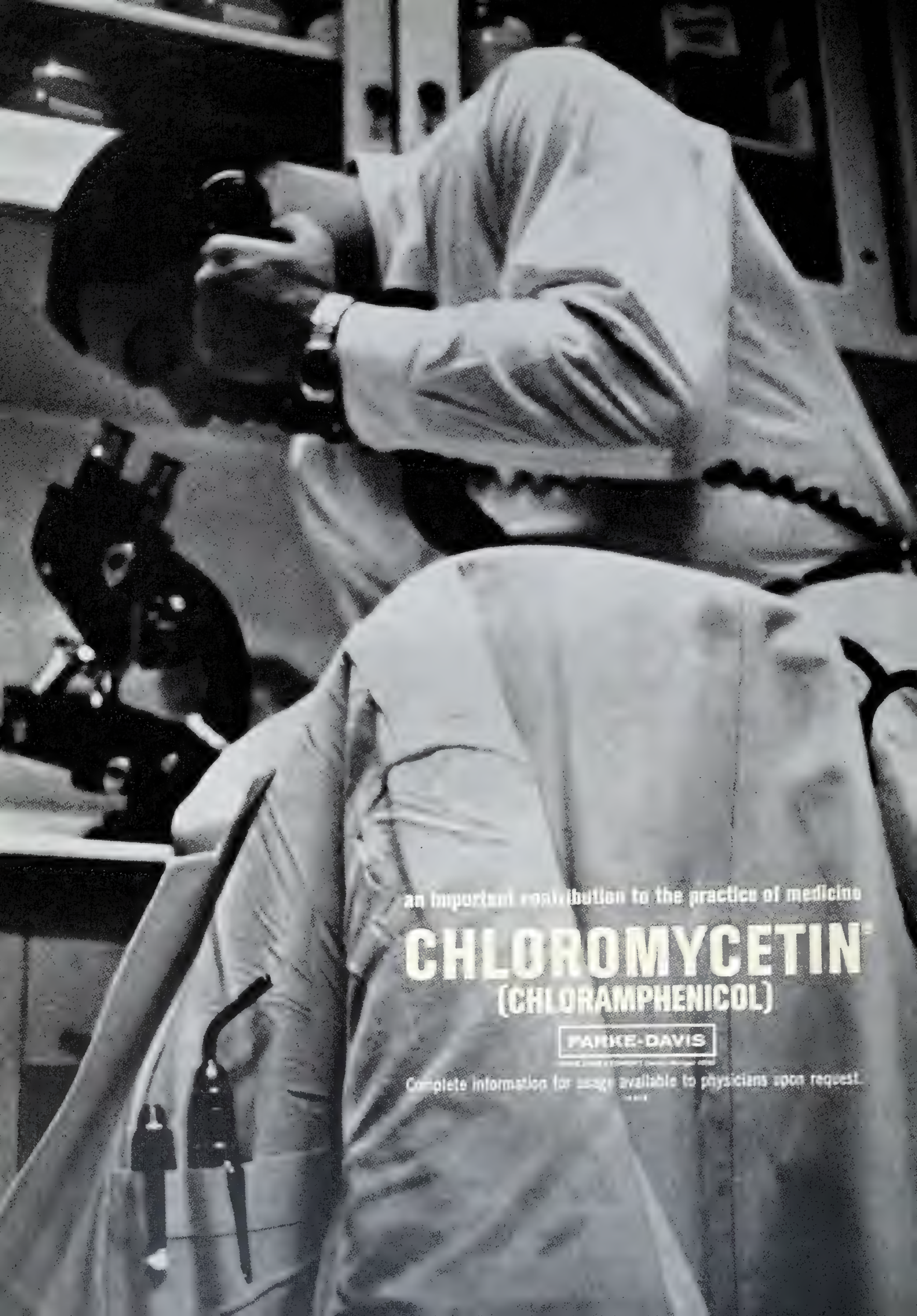

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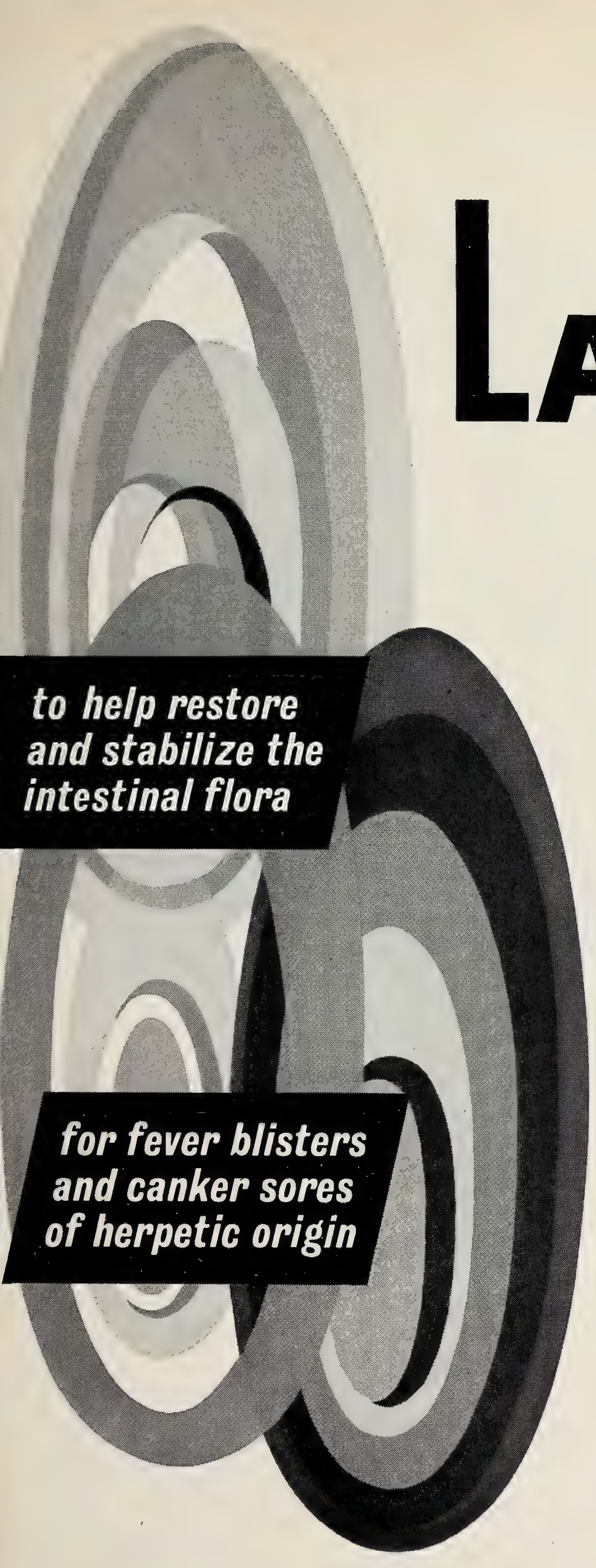
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(1) Frykman, H.M.: Minn. Med., Vol. 38, Jan. 1955. (2) Poth, E.J.: The J.A.M.A., Vol. 163, No. 15, April 13, 1957. (3) McGivney, J.: Texas State Jour. of Med., Vol. 51, No. 1, Jan. 1955. (4) Stern, F. H.: Jour. of The Amer. Ger. Soc., Vol. 11, No. 3, Mar. 1963. (5) Weekes, D. J.: N.Y. State Jour. of Med., Vol. 58, No. 16, Aug. 1958. (6) Abbott, P.L.: Jour. of Oral Surg., Anes. & Hosp. Dental Serv., Vol. 19, July 1961. (7) Weekes, D. J.: E.E.N.T. Digest, Vol. 25, No. 12, Dec. 1963.

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MICHIGAN MEDICINE

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All communications relative to manuscripts, books for review, and exchanges should be addressed to Charles J. Tupper, M.D., 2490 Adare, Ann Arbor, Michigan.

All communications regarding advertising and subscriptions should be addressed to Hugh W. Brenneman, 120 W. Saginaw Street, East Lansing, Michigan. Telephone 337-1351 (Area Code 517).

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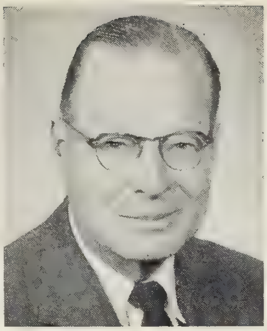

the president's message . . .

The Centennial

One hundred years of service to the people of Michigan and its doctors—that is the story of the Michigan State Medical Society.

Imagine if you will the thousands of hours of committee meetings attended by dedicated doctors from all over the state. The literally months of time donated by sacrificing officers and councilors, the splendid contributions of a conscientious staff who have worked day and night for the betterment of medicine in Michigan. All of these have made your Society one of the great state medical associations in the nation.

From September 19 through September 24 in Detroit, this century of effort will be celebrated by a Centennial Session the likes of which no state society has ever attempted.

* * *

WITH 125 speakers, closed TV, wet clinics, dry clinics, panel discussions and conferences it will be a splendid meeting.

A very real effort is being made to bring health-conscious lay groups into the program starting with the Sunday afternoon session at Ford Auditorium next to Cobo Hall. This meeting will feature a discussion of Medicine and Religion by William Menninger, M.D., president of the Menninger Foundation, Topeka, Kansas, and the Rev. Dr. Paul McCleave, director of the AMA Department of Medicine and Religion, and the Most Rev. John Weaver, former dean, Cathedral Church, St. Paul.

Organizations which have cooperated with the medical profession throughout the years will be honored during the week.

Starting Tuesday the fine exhibits will open at Cobo Hall along with the first scientific meetings.

Wednesday lectures have been arranged by the Michigan Branch of the American Academy of General Practice who have cooperated by omitting their meeting this year.

Throughout the week the Scientific Sessions have been carefully planned to interest all doctors.

* * *

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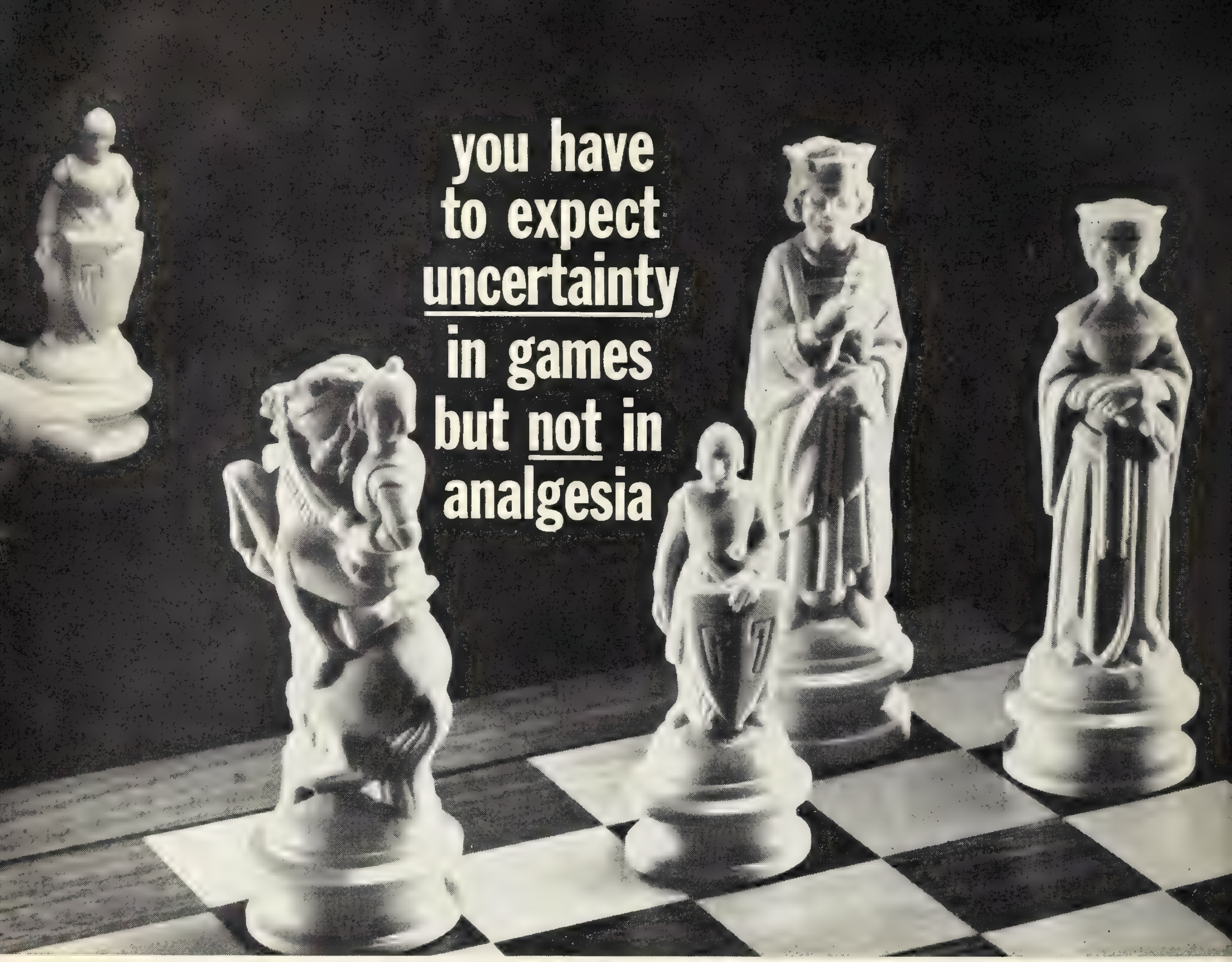

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The average adult daily dose of DECLOMYCIN Demethylchlortetracycline (600 mg.) may be considered to be the equivalent of 1,000 mg. of tetracycline per day.

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Primary and Secondary
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Tonsillitis

associated with tetracycline-sensitive organisms such as the following:

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Gonococci
Shigellae
Staphylococci
Streptococci

Evaluation in other infections and conditions is continuing.

DECLOMYCIN Demethylchlortetracycline is indicated for surgical and dental preoperative and postoperative prophylaxis of infection in contaminated fields. Since penicillin is the drug of choice for syphilis and gonorrhea, it should be employed in these infections except in patients with a history of penicillin allergy.

In cases of acute gonococcal urethritis where a primary or secondary lesion of syphilis is suspected, proper diagnostic procedures including darkfield examination should be followed. In all other cases where concomitant syphilis is suspected, serological tests should be made monthly for at least three months.

In patients with agammaglobulinemia or hypogammaglobulinemia and recurring infections, it is necessary to treat with both gamma globulin and an antibiotic such as DECLOMYCIN Demethylchlortetracycline.

DECLOMYCIN Demethylchlortetracycline *shows activity* against some strains of *Pseudomonas* and *Proteus* heretofore unresponsive to tetracycline therapy as shown by both *in vivo* and *in vitro* studies.

In the treatment of staphylococcus infections, indicated surgical procedures must be performed in all cases.

WARNING: If renal impairment exists, even usual oral or parenteral doses may lead to excessive systemic accumulation of the drug and possible liver toxicity. Under such conditions, lower than usual doses are indicated and if therapy is prolonged, demethylchlortetracycline serum level determinations may be advisable.[1,2,3]

A photodynamic reaction precipitated by direct exposure to natural or artificial sunlight has been observed in some individuals. Small amounts of drug and short exposure to these sources of sunlight may produce an exaggerated sunburn reaction which may range from erythema over the exposed parts of the body to severe skin manifestations. In a smaller proportion, photoallergic reactions to this drug, as well as other tetracycline derivatives, have also been reported.

Such patients should be warned to avoid direct exposure to natural or artificial sunlight while under treatment and to discontinue the drug at the first evidence of skin discomfort.

Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

PRECAUTIONS AND SIDE EFFECTS: The use of antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken.

Demethylchlortetracycline may form a stable calcium complex in any bone forming tissue with no serious harmful effects reported thus far in humans. However, use of demethylchlortetracycline during tooth development (= last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (=yellow-grey-brownish). This effect occurs mostly during long-term use of the drug but it has also been observed in usual short treatment courses.

As with all other antibiotics, side reactions which might be encountered include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Rare cases of anaphylactoid reactions have been reported following demethylchlortetracycline. Appropriate precaution is advised.

With full therapeutic doses in infants, increased cranial pressure with bulging fontanels has been observed. The frequency has been rare and all signs and symptoms have disappeared rapidly upon cessation of treatment.

ADMINISTRATION AND DOSAGE: *ADULT:* The average daily adult dosage is 4 divided doses of 150 mg. each or 2 divided doses of 300 mg. each. An initial dose of 300 mg. may be used in the more severe infections, but a single dose exceeding 300 mg. is thought to be unnecessary.

INFANTS AND CHILDREN: The dosage is 3 to 6 mg. per pound body weight per day or 6 to 12 mg. per Kg. per day, divided into 2 or 4 doses dependent upon the severity of the disease. This should not be given with milk formula or other calcium containing foods and should be given at least one hour prior to feeding.

Because of the cumulative effect in the body, continuation of high doses beyond the first few days is thought to be unnecessary.

Therapy should be continued beyond the time when characteristic symptoms or fever have subsided; however, DECLOMYCIN Demethylchlortetracycline, because of its unique property of prolonged stability in body fluids, permits serum activity for 24 to 48 hours after the last dose. The incidence of rheumatic fever or glomerulonephritis following streptococcal infections suggests that therapy of a streptococcal infection should be continued for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Primary Atypical Pneumonia (Eaton Agent): The average adult daily dosage is 900 mg. in 3 divided doses for six days.[4,5,6]

In the treatment of pustular acne vulgaris an initial dose of 600 mg. daily for one or two weeks may, in most cases, be reduced to 300 mg. or 150 mg. daily for remainder of treatment course.[7]

Absorption is impaired by the concomitant administration of high calcium content drugs such as some antacid medications, foods and some dairy products such as milk. Oral forms of demethylchlortetracycline should be given 1 hour before or 2 hours after meals.

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ADVICE TO AUTHORS:

1. Address scientific manuscripts to Editor, Michigan Medicine, C. J. Tupper, M.D., 2490 Adare, Ann Arbor, Michigan.
2. Submit original, double-spaced typewritten copy and one carbon copy on letter size (8½ x 11 inch) paper.
3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.
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6. References will ordinarily be limited to seven in number. Exceptions may occassionally be made.
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8. Articles should ordinarily be less than four printed pages in length (3000 words).
9. References should conform to *Cumulative Index Medicus*, including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.
10. Specify address to which galley proof should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.
11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.
12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

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BREAKING NEWS—571-574

NEWS BRIEFS

Henry J. Vanden Berg, Jr., M.D., Grosse Pointe, active in MSMS cancer control committee work, discussed "Smoking Hazards: An Approach to the Porblem" at the annual meeting of the Genesee County Tuberculosis Association at Flint.

Thomas Davies, M.D., Wayne County deputy health director, was honored recently by the Wayne County Board of Health for his 30 years of service to Grosse Pointe and Harper Woods and for his "compassionate concern for his fellowman."

E. Gifford Upjohn, M.D., Kalamazoo, board chairman of The Upjohn Company, recently was elected as a director of the Consumers Power Company.

William L. Rogers, M.D., Grand Rapids, has been appointed prison doctor at the Michigan Reformatory at Ionia. He succeeds Russell Finch, M.D., who died earlier this year.

John R. Beljan, M.D., formerly of Ann Arbor, is the new director of medical services for The Stuart Company Division of Atlas Chemical Industries, Inc. Doctor Beljan went to Stuart from the U.S.A.F. Hospital, Perrin Air Force Base, Texas, where he was hospital commander and director of base medical services. Prior to Air Force service, he was a clinical instructor in surgery at University Hospital, Ann Arbor. He was graduated from the University of Michigan Medical School in 1954.

The Home Care Program of the Detroit Visiting Nurse Association was the topic of discussion in Brussels, Belgrade and Paris this summer. **Sidney E. Chapin, M.D.**, Dearborn, Medical Director of the program, will be discussing the administrative aspects of coordinated home care and the economies of such a program with Government Officials and Visiting Nurse Association in Brussels, Belgrade and Paris.

R. W. Sarber, Ann Arbor, has several busy months ahead as executive secretary of the International Congress of Chemotherapy as he plans the 4th annual congress at Washington, D. C., October 18-21.

Speakers at the 21st annual convention of the Michigan Practical Nurses Association in Grand Rapids this summer included **Samuel Noordhoff, M.D.**, Grand Rapids, who discussed his five years of service in Taiwan; **Philip J. Hoekstra, M.D.**, Grand Rapids, on "Hydrocephalus," and **Richard C. Bates, M.D.**, Lansing, on "How to Have a Heart Attack."

The new president of the Muskegon County Unit, American Cancer Society, is **James Stubbart, M.D.**, who advanced from the vice-presidency. Arthur H. Joistad, Jr., M.D., and Robert E. Bloom, M.D., serve as medical co-chairmen.

Mary Esther Woodworth of Alto, now a medical technologist at Temple University Hospital, was honored at the American Society of Medical Technologists convention in Cincinnati when she received the Annual Kimble Medical Technology Award. She is credited as being the first to develop a method of applying programmed teaching in the field of medical technology at Temple. She holds a B.S. from the University of Michigan and is working toward a Ph.D. at Temple.

Sylvester W. Trythall, M.D., Detroit, senior attending gynecologist at Crittenton General Hospital, received a Distinguished Alumni Award at the commencement exercises at Northern Michigan University. Doctor Trythall was cited for "outstanding contributions to education, professional leadership and community service."

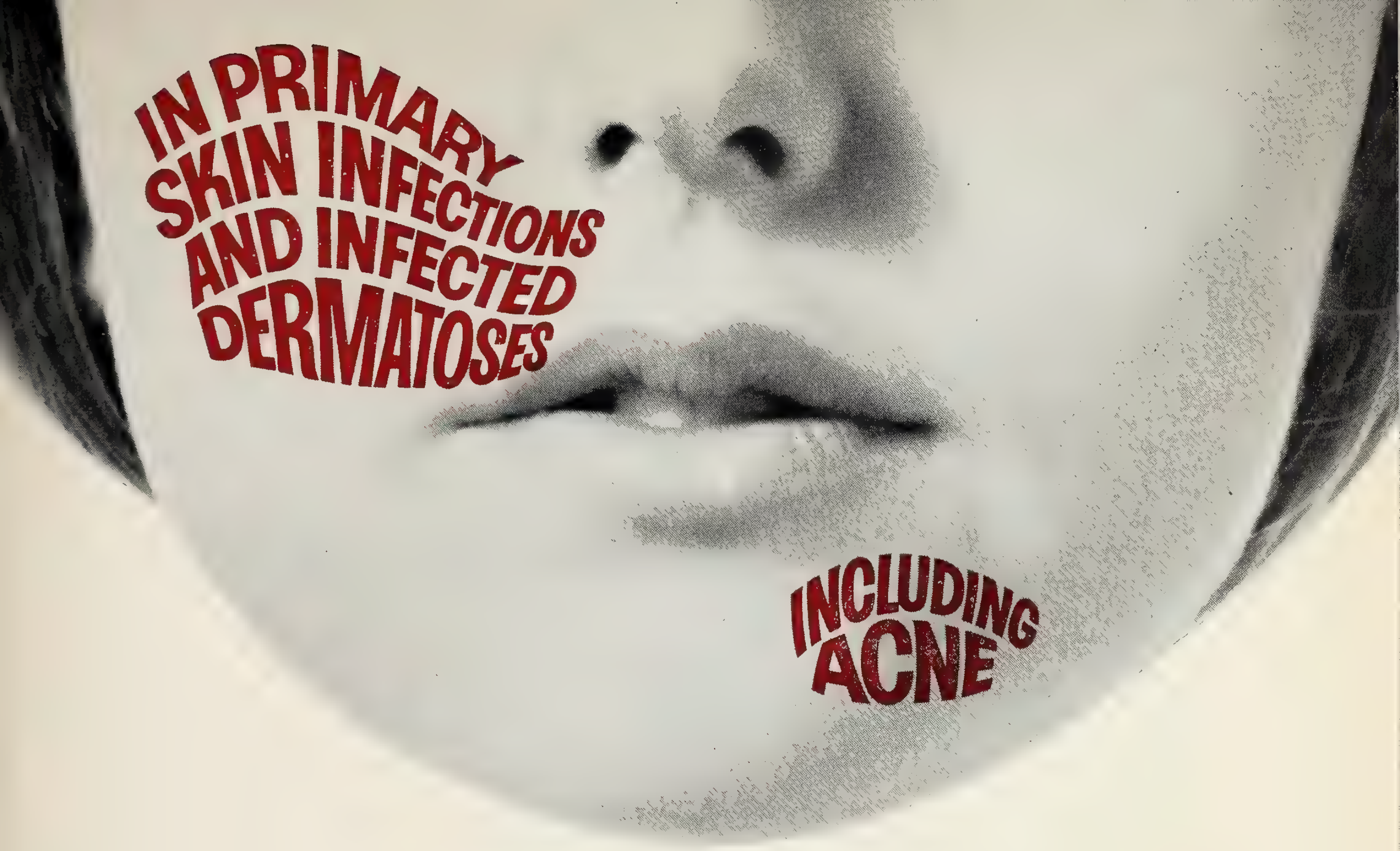
Jerry M. Gray, M.D., Monroe, a fourth-year resident in pathology, was the recipient of the Resident Achievement Award presented annually by the University Hospital at Ann Arbor.

The Wayne State University adult series of 10 lectures on "Psychoanalysis and the Modern World," which attracted a total audience of more than 4,000 at the Rackham Auditorium, closed with **Richard F. Sterba, M.D.**, as the final speaker. Doctor Sterba is a professor of psychology at WSU.

Several physicians have appeared recently on the Michigan Health Council television program. **H. D. Ireland, M.D.**, Grand Rapids, discussed "Emphysema" over WZZM-TV; **Robert G. Prophater, M.D.**, Bay City, discussed the "MSMS Centennial" over WNEM-TV at Saginaw; and **William A. Fishbeck, M.D.**, Traverse City, talked about "Medical Needs for Expectant Mothers" over WWTV and WWUP-TV at Cadillac and Sault Ste. Marie.

One of the five guest professors at the University of Wisconsin Medical Center program, August 26-28 on "Current Concepts in Surgery" will be **Clifford D. Benson, M.D.**, clinical associate professor of surgery at Wayne State University.

A contract from the U.S. Army Medical Research and Development Command for $51,469, will provide funds at Wayne State University for the continuation of the "Head Injury" research direct by **E. S. Gurdjian, M.D.**, and **L. Murray Thomas, M.D.**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Members are invited to submit to the Journal any suggestions for the welfare of the Society, as well as comments or criticisms of any material in the Journal. All such communications should be directed to the Publication Committee of the Journal. The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted to it.

Dear Doctor Tupper:

It is very nice to hear that our "Note on the Scalene Node and the Problem of Sarcoidosis" has been accepted. I have always had an excellent response to the articles that have appeared in the MICHIGAN MEDICINE—more mileage than some of the national journals have provided.

Cordially yours,
ALBERT DEGROAT, M.D.
Director, Bureau of Laboratories
Department of Health, Detroit

* * *

Dear Doctor Tupper:

I am writing you as editor of MICHIGAN MEDICINE so that through the journal you may inform members of the Michigan State Medical Society of their opportunity to participate in the program of the Medical Committee for Human Rights. This organization has acted as the medical arm of the civil rights movement furnishing assistance to civil rights workers in Mississippi and by participating in the March on Montgomery from Selma, Alabama, led by Reverend Martin Luther King. Michigan participants in the March included Doctors Charles Wright, Joseph Lenzo, and Paul Lowinger. In addition to participation in the civil rights movement MCHR is also concerned with discrimination against minority groups in the distribution of medical care including the patterns of hospital practice. It devotes efforts to the improvement of public health activity with respect to the poor and disadvantaged segments of the population in both the North and South. Physicians, nurses, and other medical personnel who wish to make a contribution to the efforts of MCHR may do so by contacting the National Office at 211 West 56th Street in New York or the local Chairman, Dr. Robert Axelrod at 13725 West Eight Mile, Detroit.

Sincerely,
PAUL LOWINGER, M.D.
Associate Professor
Department of Psychiatry
Wayne State University

Dear Doctor Tupper:

On April 7, at noon, 30 physicians of a newly organized Physicians for Automotive Safety made a "dignified protest" before the 1965 International Automobile Show at the New York Coliseum. Fourteen specific objections to current automobile design were indicated on the placards which the physicians carried. Since the protest, the response from the public and our fellow physicians reflects sentiment that our action was long overdue. Despite past intensive programs directed at control of the environment (the highway) and the host (man), little attention has been directed towards preventive countermeasures for the specific agent (the automobile). Defective automobile design is responsible for much of the epidemic injury, disfigurements, and disabilities.

All the previous resolutions of the American Medical Association and the American College of Surgeons asking that the industry make a safer car have been almost completely ignored. There will be no conflict with the regular medical organization activities on automotive safety, and the Physicians for Automotive Safety will cooperate to reinforce the mutual objective.

The Physicians for Automotive Safety, as a smaller and more flexible organization, will direct programs specifically to effecting occupant protection in motor vehicles. Physicians for Automotive Safety represents the first attempt at organization of the practicing medical profession to cope with a known mechanical epidemiologic agent. The nature of the present epidemic clearly justifies this approach.

Membership inquiries and suggestions for future action should be directed to Dr. Arnold Constad, Secretary-Treasurer, 527 Morris Avenue, Springfield, New Jersey. Basic membership fee is $5, contributing membership $15, sustaining membership $25 per year. Hopefully, physicians from every section of the country will join to give meaningful influence for this new medical group.

Sincerely yours,
SEYMOUR CHARLES, M.D.
President
Physicians for Automotive Safety
Newark, New Jersey

* * *

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Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning: If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Side effects
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

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These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient cannot be seen regularly, when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin® alka are contraindicated in patients with glaucoma.

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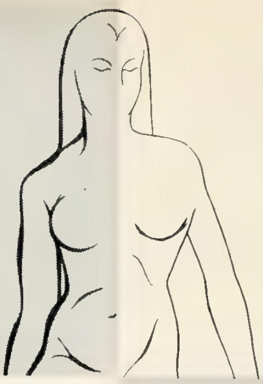

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*This one at Oak Creek, Castle Rock, Arizona

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SYMPTOMATIC CONTROL OF COUGH IN RESPIRATORY ALLERGIES WITH CHLORTRIMETON® EXPECTORANT

By **SAMUEL J. LEVIN, M.D.**[*]
and **ROBERT A. SCHERER, M.D.**[†]
BOTH OF DETROIT

The definitive treatment of common respiratory allergies such as asthma, perennial allergic rhinitis, and hay fever is both difficult and time-consuming. Antigens must be identified and if possible eliminated from the patient's diet and environment; desensitization (immunization) and other long-term therapeutic procedures are usually necessary to bring the condition under control.

While such procedures are being carried out, it is important that the patient be given effective relief of symptoms.

For more than two decades, antihistamines have been widely used in the symptomatic control of respiratory allergies. Many investigators have reported that one such antihistamine, chlorpheniramine maleate, is highly effective against a variety of respiratory disorders of allergic origin, and its administration is usually accompanied by minimal side effects.

* * *

RECENTLY an expectorant containing chlorpheniramine[‡] was made available to physicians. Since this new dosage form seemed to offer certain advantages, especially for patients with severe coughing and nasal congestion, we undertook a clinical study of its effects on a cross-section of patients with respiratory allergies.

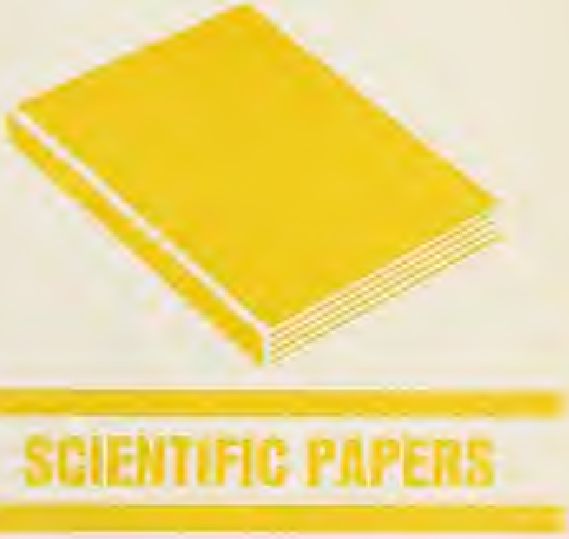
METHODS

Of the 84 patients in this study, 55 were preadolescent children, ranging from 3½ to 12 years of age. The remaining 29 patients ranged in age from 13 to 63 years. The combined group comprised 39 males and 45 females. There were 34 males and 21 females among the children, and 24 females and five males among the adults.

TABLE I

Diagnoses	Number of Patients Children	Adults	Total
Asthma	23	15	38
Perennial Allergic Rhinitis (P.A.R.)	18	9	27
Allergic Tracheitis	5	0	5
Hay Fever	2	1	3
P.A.R. with Asthma	3	1	4
Asthma	2	0	2
Allergic Bronchitis	0	2	2
Asthma with Hay Fever	1	0	1
Allergic Croup	1	0	1
P.A.R. with Hay Fever	0	1	1
Total	55	29	84

Asthma and perennial allergic rhinitis were the most common diagnoses among both children and adults (Table I). Coughing was a major symptom in the patients selected for this study. All patients were given Chlor-Trimeton Expectorant as the sole agent for relief of coughing. Two forms of the expectorant were used: one contained codeine (this was prescribed for 46 patients) and the other (prescribed for 38 patients) did not. The usual dosage was one teaspoonful every four hours for children and two teaspoonsful every four hours for adults.



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[*] Clinical Professor of Pediatrics, Wayne State University College of Medicine; Director of the Allergy Section of the Children's Hospital of Michigan; Associate Pediatrician, Harper Hospital; and Associate in Medicine (Allergy), Sinai Hospital, Detroit.

[†] Clinical Instructor of Pediatrics, Wayne State University College of Medicine; Allergist and Assistant Pediatrician, Children's Hospital of Michigan, Detroit.

[‡] Chlor-Trimeton Expectorant, Schering Corporation, Bloomfield and Union, New Jersey. Each 5 cc. contains Chlorpheniramine maleate 2 mg., phenylephrine hydrochloride 10 mg., ammonium chloride 100 mg., sodium citrate 50 mg., glyceryl guaiacolate 50 mg., chloroform 12.5 mg., and alcohol 1 per cent or less. Chlor-Trimeton Expectorant with Codeine contains, in addition, codeine phosphate 10 mg. and alcohol approximately 5.25 per cent.

TABLE II

Results	Number of Patients	Very Good	Good	Fair	Poor	Side Reactions
Chlor-Trimeton Expectorant						
Children	24	3	19	1	1	0
Adults	14	0	8	3	3	1
Total	38	3	27	4	4	1
Chlor-Trimeton Expectorant with Codeine						
Children	31	5	14	6	6	0
Adults	15	2	8	3	2	1
Total	46	7	22	9	8	1

The duration of treatment ranged from one week to several months.

RESULTS

As Table II indicates, results for the entire group under study were: very good, ten patients; good, 49; fair, 13; poor, 12. Thus the medication evidently provided definite benefit to 59 (about 70%) of the 84 patients and at least partial relief to 72 patients (about 86%). Very good or good results were obtained for 41 (about 75%) of the 55 children and for 18 (about 62%) of the 29 adults.

The general reaction of patients and of parents of the children was that coughing, congestion, and other symptoms of respiratory disorder were greatly alleviated by the use of the medication. The expectorant also seemed singularly free of side reactions often associated with the antihistamines. The only instances of side reactions occurred in two adults who complained of drowsiness while on a dosage of two teaspoonsful every four hours. In each case drowsiness disappeared when the dosage was reduced to one teaspoonful every four hours. One patient found the taste disagreeable.

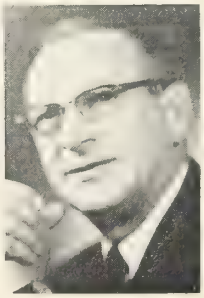
COMMENT

For most patients in both age groups, the degree of relief attributable to Chlor-Trimeton Expectorant was as great or greater than we have observed with other expectorants. Results were especially good among patients with asthma or perennial allergic rhinitis. In cases where coughing did not disappear, it usually became noticeably less persistent.

Among the children in this study were five with allergic tracheitis, which is generally very resistant to any type of symptomatic medication except corticosteroids.[8] Results were poor in two of these cases, but two children with this condition were definitely benefited and fair results were noted in the other case.

Results were somewhat better among the children than among the adults in this study, but this is probably not significant because, as would be expected, there was a greater proportion of chronic disease among the adult group. Nor does it appear to be significant that better results were obtained with the medication without codeine, because the patients who received Chlor-Trimeton Expectorant with Codeine generally had more severe coughing when this symptomatic treatment was begun. It is worth noting, however, that coughing was a problem even in those patients who received the medication without codeine, and that in 30 of these 38 patients, very good or good results were obtained.

CO-AUTHOR
Samuel J. Levin, M.D.



SUMMARY

A new expectorant form of Chlor-Trimeton was prescribed for relief of coughing and related symptoms in 84 patients with various respiratory allergies including asthma, perennial allergic rhinitis, and allergic tracheitis. Results were very good or good in 41 (about 75%) of the 55 children under study and in 18 (about 62%) of the 29 adults. The only reported side reactions were in two patients with drowsiness; this disappeared when dosage was reduced.

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470 Fisher Building
Detroit, Michigan

THE DETECTION

Of Uterine Cancer By Diagnostic Cytology

An analysis of five years experience with a cancer cytology screening program, organized by a county medical society so as to provide a readily available screening service to the private practice of medicine in the community, is presented. Diagnostic cytology as a reliable method for the detection of cancer of the female genital tract has been firmly established and results obtained in this program compare favorably with those obtained in other series.

The importance of appropriate follow-up studies and of periodic cytologic re-evaluation of every adult woman is stressed.

BY WAYNE L. EATON, M.D.

FLINT

In 1957, a cancer cytology program was organized in Genesee County, Michigan, through the cooperative efforts of the Genesee County Medical Society, the Genesee County chapter of the American Cancer Society, and the pathologists serving the community. This program was to be primarily concerned with detection of cancer of the female genital tract, and was based on two concepts:

(1) *The detection of uterine cancer by cytologic methods affords a reliable, reasonably simple, and realtively inexpensive screening method, and,*

(2) *One of the best cancer detection centers is the individual physician's office.*

This report is an analysis of the results of the first five years' experience with this program.

Materials and Methods

All material submitted was obtained by physicians from their private patients. Under these circumstances, selection has been quite variable. Some physicians have used this service extensively, screening all their adult female patients. Others have been more selective in their choice of patients for this examination.

Two smears were obtained from each patient by her physician. One was prepared from an aspirate or swab of the vaginal pool. The other was prepared from scrapings of the cervical os and adjacent endocervix. Smears were immersed immediately in a fixative. Initially alcohol-ether was utilized for fixation. During the past three years, acetone has been used with equally satisfactory results and has the additional advantages of being less volatile and less expensive. Smears were stained by the method of Papanicolaou.

* * *

THE NUMBER OF CASES examined has increased each year to a current volume of more than 30,000 cases per year. During the first five years, 52,159 cases were examined. Of these, about 12,000 were repeat examinations. Thus, approximately 40,000 individual women were examined during this period.

Smears were classified according to the method of Papanicolaou. There were 394 women from whom suspicious or positive smears (Papanicolaou Classes III, IV, and V) were obtained. Among these were 26 "borderline smears" listed as Class II-III. These were so-called because of paucity of atypical cells, but were followed in the same manner as Class III smears.

The majority of patients with abnormal smears had diagnostic biopsies for further evaluation. Diagnostic cold knife conization biopsies and/or endometrial curettings were obtained for histologic study in preference to other biopsy techniques.

A summary of these 394 cases detected by cytologic study is presented in relation to their diagnostic follow-up in Table I. The cytologic classification listed is that made on the first smears examined from each of the patients, although a num-

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From the Flint Medical Research Foundation, 633 Mott Foundation Building, Flint 2, Michigan.

TABLE I

	Diagnostic Follow-up	Initial Cytologic Classification				No. of Cases
		II-III	III	IV	V	
A	BIOPSY-CANCER PRESENT:					
	Squamous cell carcinoma **in-situ** of cervix uteri	5	59	6	72	142
	Squamous cell carcinoma, invasive, of cervix uteri	1	17	3	31	52
	Adenocarcinoma of endometrium	0	1	2	1	4
	Cancer metastatic to uterus	0	0	0	3	3
	TOTAL CASES WITH POSITIVE DIAGNOSIS OF CANCER	6	77	11	107	201
B	BIOPSY—EQUIVOCAL HISTOLOGIC CHANGES:					
	Epithelial dysplasia (Atypical squamous metaplasia)	2	41	3	11	57
C	BIOPSY—NO CANCER PRESENT:					
	Cervicitis with or without dyskaryosis and/or epidermidization	3	28	1	6	38
	Benign squamous metaplasia in endocervix	3	7	0	0	10
D	POST-RADIATION SMEARS WITH ATYPICAL CELLS	0	4	0	3	7
E	NO BIOPSY—SMEARS REVERTED TO NORMAL ON CYTOLOGIC FOLLOW-UP:					
	Reversible dyskaryosis associated with pregnancy	0	5	0	1	6
	Reversible dyskaryosis associated with severe cervicitis	4	25	0	2	31
F	NO FOLLOW-UP AVAILABLE:					
	Patient refused definitive diagnosis and therapy	1	3	0	3	7
	Patient moved, has not returned, etc.	7	23	1	6	37
	TOTAL CASES WITH SUSPICIOUS OR POSITIVE SMEARS	26	213	16	139	394

ber of patients had repeat smears examined prior to more definitive diagnostic studies.

Discussion

The incidence of approximately 1 per cent suspicious and positive cases detected in this study is somewhat lower than has been observed in some studies in this country.[1] Definitive histologic study has revealed the presence of cancer in 201 of the 394 women. Squamous cell carcinoma of the cervix uteri was present in 194 of these patients; of these, 142 had carcinoma *in situ*. In relatively few patients with carcinoma *in situ* was a clinically suspicious lesion present. This was also true of a significant number of patients in whom invasive carcinoma was found.

Of practical importance is the fact that smears obtained from the endocervix almost invariably contained many more neoplastic cells than smears of the vaginal pool. There has been no clearly defined correlation between the cytologic classification and stage of cancer. Patients with Class III smears should have the same diagnostic follow-up studies as patients with Class IV and Class V smears.

* * *

THE RELATIVELY FEW cases of endometrial carcinoma encountered in this series probably reflects the different characteristics of this disease. Endometrial carcinoma is much more apt to be associated with abnormal uterine bleeding leading to diagnostic endometrial curettage. Most diagnoses, at least in this community, are made by this approach.

One of the most perplexing problems relating to the histologic diagnosis of carcinoma, particularly of the cervix uteri, is the lesion variously designated as epithelial dysplasia, atypical squamous metaplasia, atypical hyperplasia, anaplasia, etc. There is variation of opinion among pathologists as to criteria for diagnosis of this lesion and its differentiation from *in situ* carcinoma. That the lesion so designated exists in association with developing carcinoma has been clearly defined.[2] In such instances, it most likely represents a progressive change, that is, an earlier phase in a developing carcinoma. Histologically identical lesions may also be reversible. Since histologic differentiation of so-called epithelial dysplasia from early carcinoma may be difficult, cytologic differentiation is certainly not to be expected.

In this series, 57 patients had such lesions. Some of these have had persistent negative cervical smears following cervical conization. Others have had subsequent histologic studies in which carcinoma *in situ* has been demonstrated. It is imperative, then, that such diagnoses as atypical metaplasia be regarded seriously, and that very close follow-up of the patient, at least by cytology, be maintained.

* * *

IN ANY SERIES of cytologic studies there will be a certain number of patients from whom morphologically suspicious cells are obtained, yet follow-up studies fail to reveal cancer. In biopsy material from these patients, particularly those with active, severe inflammation, the epithelial cells may reveal many of the features of malignant neoplastic cells, yet such changes are clearly defined histologically as related to the inflammatory process.

When abnormal smears are obtained during pregnancy, particularly early pregnancy, or from cervices in which there is an active infection, it is frequently worthwhile to treat the existing process and follow such patients by cytologic methods. A significant number will have a return to normal morphology following cessation of the process. Those who have persistent cytologic abnormalities should have appropriate biopsy and histologic evaluation.

In this series, seven patients have been encountered in whom there was a previous history of carcinoma of the cervix uteri treated by radiation, and who developed abnormal smears one to seven years following radiation therapy. Two of these patients have been proven to have squamous cell carcinoma **in situ** developing anew in the cervix uteri or vaginal vault. The origin of the abnormal cells in the other five patients has not been determined. Three had biopsies which revealed only irradiation atrophy and fibrosis. One patient died and no post-mortem examination was obtained.

Five of the patients in the group with squamous cell carcinoma *in situ,* who were treated by hysterectomy, initially had negative smears post-operatively, but developed positive smears again one to three years later. In four of these patients a diagnosis of squamous cell carcinoma *in situ* of the vaginal cuff has been established by biopsy.

* * *

SUCH EXPERIENCES, which have also been observed by others,[3] indicate clearly the need for continued close follow-up of patients with cancer who have had definitive therapy. In cancer of the female genital tract, diagnostic cytology affords the best method of following such patients.

In this series of some 40,000 patients, there have been eight patients from whom smears were reported negative (most were Class II), and in whom carcinoma of the cervix uteri or endometrium was discovered within the following year. All smears of these cases were reviewed. In three cases, cancer cells were identified, although in sparse numbers. Smears from the other five cases contained no neoplastic cells. Thus, a single negative sampling of material does not always assure that the patient is free of cancer.

One of the three false negative smears was from an elderly woman with a granular lesion of the exocervix. There were numerous keratinizing cells in the smear. Despite the negative (Class II) cytologic report, the physician was suspicious of the lesion and it was biopsied. This revealed a well differentiated keratinizing squamous cell carcinoma of the exocervix. This case, which represents an error in cytologic interpretation, serves to stress an additional point, namely, that when a suspicious lesion is evident clinically, primary biopsy may be the preferable approach to definitive diagnosis. Diagnostic cytology has its greatest value before the lesion becomes clinically manifest.

* * *

AN ANALYSIS OF the cases of squamous cell carcinoma of the cervix indicates that the *in situ* stage tends to appear, on the average, about a decade earlier. In this series the average age of patients with carcinoma *in situ* was 38 years at the time of diagnosis. The youngest patient was 19 years; the oldest 66 years. With regard to invasive carcinoma of the cervix uteri, the average age was 48 years at time of diagnosis. The youngest patient in this group was 28 years; the oldest 70 years. Thirty-four patients in the entire group were under the age of 30 years, although only three were less than 25 years old. Thus, this lesion begins in a significant number of women in the third decade of life, and it therefore appears desirable to begin routine cytologic screening of patients soon after their twentieth birthday.

Summary

An analysis of results of a cancer cytology screening program in Genesee County, Michigan, is presented. This program has been concerned primarily with the detection of uterine cancer.

One per cent abnormal smears were obtained from 40,000 women examined during the first five years. Of those with abnormal smears who have had adequate follow-up study, approximately 75 per cent have been proven to either have cancer or border-line lesions.

Early carcinoma of the cervix uteri usually presents no clinically evident lesion. Cytologic study affords the simplest, reliable method for its detection.

All patients with persistent positive abnormal cervical and vaginal smears must have additional studies to establish definitive diagnosis. These include diagnostic quadrant biopsies, cold-knife conization biopsy of the cervix uteri, and diagnostic curetting of endometrium.

* * *

ALL PATIENTS with proven diagnosis of cancer

AUTHOR
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Acyanotic Heart Disease In Infancy

Experience with systemic-pulmonary cardiovascular communications and coarctation of the aorta in the first year of life

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ALL OF DETROIT

With the significant increase in acyanotic heart disease diagnosed in infancy and the precision with which it can now be delineated, both diagnostically and prognostically, it becomes increasingly important to recognize the methods of therapy to which these cases are amenable and the results of such therapy. Certainly the most dramatic advance in the management of congenital heart defects has been in the surgical area.

Too often, however, the success of a new surgical approach to congenital heart disease is considered within the framework of outmoded medical statistics.

It is the purpose of this communication to update the medical experience with systemic-pulmonary communications and coarctation of the aorta in the first year of life.

Materials and Methods

In compiling the infant experience with systemic-pulmonary shunts and coarctation of the aorta, all hospital admissions for acyanotic heart disease in children less than a year of age from the year 1961 through 1963, were reviewed for inclusion in this study. Acyanotic heart disease was defined in this study as including defects accommodating left-to-right shunts at the atrial, ventricular or patent ductus arteriosus levels and coarctation of the aorta. Other acyanotic malformations such as

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Conclusion: The Detection of Uterine Cancer . . .

of the uterus should be followed indefinitely, regardless of type of therapy. A certain number of such patients can be expected to develop other areas of cancer in the genital tract. Diagnostic cytology is an accurate method by which to follow these patients.

Positive cytologic studies do not invariably mean that cancer is present. However, failure of reversal to persistent negative smears following appropriate treatment for any other possible cause of the abnormal cells indicates the need for intensified efforts to detect the source of such cells.

A negative cytologic study does not necessarily exclude the presence of cancer. Although false negative interpretations should be infrequent, they do occur. Furthermore, although sampling of vaginal and cervical material, in most cases, will incorporate neoplastic cells, if present, this is not always the case. Thus, periodic cytologic examinations, at least annually, are a desirable addition to the periodic health examination of all women over the age of 20 years, and should be made correspondingly more frequently when clinical and cytologic studies so indicate.

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fibroelastosis, myocarditis, other cardiomyopathies, pulmonic and aortic stenosis were not further studied beyond including them in the total number of infants admitted with acyanotic heart disease. The diagnosis of left-to-right shunts and coarctation of the aorta, was in the majority of instances, accomplished by hemodynamic studies, cineangiocardiographic techniques, or by post mortem examination.

* * *

ALL CASES WERE analyzed for the predominant lesion precipitating clinical difficulty, the method of therapy employed, and the results of such therapy within the first year of life. Since this communication is directed in part to determining the advantages of medical and surgical therapy in early infancy, a detailed consideration of therapeutic results beyond the first year of life was felt to be beyond the scope of this study.

Of 166 children admitted in the study period with acyanotic heart disease, 131 were diagnosed as having a potentially correctable lesion such as coarctation of the aorta, septal defect or patent ductus arteriosus (Table I). It is to these cases that our attention has been directed.

Results

Of the 131 cases of potentially correctable acyanotic heart defects seen in the last three years, 104 were treated medically (Table II). The remaining 27 cases were additionally treated with one of several surgical procedures (Table II). Of those treated medically there was a total of 26 deaths. Fifteen of these 26 cases, however, were complicated by such additional lesions as mongolism, coexistent fibroelastosis, multiple non-cardiac congenital anomalies, or other miscellaneous conditions such as severe enteritis or renal failure. The remaining 11 patients died primarily as a result of their heart lesion; of these, only two were six months of age or older.

Table I. Acyanotic Heart Disease in infants less than one year of age admitted to Children's Hospital in Michigan from 1961 through 1963.

Left-to-Right Shunts		115
Ventricular Septal Defects	62	
Patent Ductus Arteriosus	38	
Atrial Septal Defects	15	
Coarctation of Aorta		16
Fibroelastosis		18
Myocarditis		6
Miscellaneous		11
Total		166

Table II. Surgical experience with acyanotic heart disease in infants less than one year of age admitted to Children's Hospital of Michigan from 1961 through 1963.

Surgery	Total	Survival
Ligation of Patent Ductus Arteriosus	14	13
Pulmonary Artery Band (All Ventricular Septal Defects)	9	7
Resection of Coarctation	4	2
Total	27	22

Twenty-two of the 27 patients treated surgically survived. All procedures were extracardiac and did not involve the use of extracorporeal circulation. These patients, moreover, received maximum medical therapy prior to the performance of the surgical procedure. While surgery was considered urgent in virtually every case, it was withheld until the patient had maximum medical therapy.

Ventricular Septal Defects

Of the 115 children less than a year of age admitted with systemic-pulmonary communications, 62 had ventricular septal defects. The vast majority of these infants presented with congestive failure often complicated by pneumonitis. Respiratory distress and growth failure were seen most frequently in this group. Fifty-three of these infants were treated medically; six of these failed to survive the first year of life because of their septal defect alone (Table III). Only one of the six, however, was six months of age or older. These children dying under medical management were as a rule not only extremely ill, but often admitted late in the course of their illness, and therefore, were not the recipients of maximum medical effort.

Nine children with predominant ventricular septal defects were treated surgically. Seven were six months of age or less; and six weighed less than 4.5 kilograms. The procedure in all cases consisted of banding the pulmonary artery. Seven of the nine cases survived this procedure. Of the seven survivors, one patient died of a pulmonary artery aneurysm which ruptured 4½ months after the surgical procedure (the shortest follow-up period).

Patent Ductus Arteriosus

Congestive failure was less frequently a problem in this group of 38 patients. The usual clinical situation leading to discovery of a patent ductus arteriosus with cardiac disability was pneumonitis in a patient demonstrating a systolic murmur at the left upper precordium in whom further examination revealed cardiac enlargement and often, coexistent congestive failure. Of the 38 patients with this predominant defect, 14 were operated with 13 survivals. Most of these operated infants demonstrated severe, often refractory congestive failure. These same babies demonstrated the greatest retardation of growth, although growth failure in the group as a whole was generally not as prominent as in infants with ventricular septal defects.

Of the remaining 24 infants, six died within the first ten days of life from *non-cardiac* causes as

Table III. Medical experience with potentially correctable acyanotic heart disease in infants less than one year of age admitted to Children's Hospital of Michigan from 1961 through 1963.

Lesion	Total Cases	Survivals	Deaths		
			Total*	Uncomplicated	
				Less than 6 mos.	More than 6 mos.
Ventricular Septal Defects	53	44	9	5	1
Patent Ductus Arteriosus	24	16	8	1	0
Coarctation of the Aorta	12	6	6	2	1
Atrial Septal Defects	15	12	3	1	0
Total	104	78	26	9	2

*Includes cases complicated by mongolism, co-existent fibroelastosis and multiple noncardiac congenital anomalies.

determined by autopsy studies. A seventh died at one month of age and the eighth patient died at four months of age. All but one of the eight patients dying with this defect had major complicating lesions of the types enumerated above.

None of the surviving unoperated cases had unequivocal congestive failure.

Atrial Septal Defects

Patients with this defect presented with little more than moderate, if any, growth failure, complicated by the finding of cardiac enlargement and pulmonary hypervascularity evident on x-ray examination of the chest. Pneumonia was not as frequent a problem in this group. Congestive failure was present in three of the total of 15 cases seen in the first year of life with this defect. Two such cases responded well to medical therapy. The third died with a pneumonitis due to Friedlander's bacillus and Escherichia Coli. Two other children died with this defect (ostium primum type) within the first four months of life; both had Down's Syndrome with multiple congenital anomalies.

No child in whom the diagnosis of atrial septal defect was made, was considered a candidate for surgery. One infant with an atrial septal defect had an associated partial anomalous pulmonary venous drainage, but the former lesion was considered to be the predominant one.

Coarctation of the Aorta

Sixteen infants were admitted to Children's Hospital in the first year of life in whom this diagnosis was the predominant cardiovascular lesion. Hospitalization was required usually because of congestive failure. These infants were subjected to a course of intensive medical therapy to which some responded quite favorably.

Six patients failed to survive on medical therapy. In three of the six, death was due primarily to the consequences of the coarctation of the aorta alone. The remaining three died with associated defects such as 16-18 trisomy accompanied by multiple non-cardiac congenital anomalies, or severe fibroelastosis. Five of the six dying on medical management did so within the first 27 days of life.

Four patients with coarctation of the aorta were felt to have benefited maximally from medical therapy with a suboptimal response and were therefore treated surgically. All were six months of age or less. The two surviving patients were found to have complicating left-to-right shunts, but following correction of coarctation of the aorta did well. The ages of those children not surviving surgery were one month and 2½ months of age. In the older child, autopsy examination demonstrated the presence of a hypoplastic left heart complex.

Discussion

Infants with left-to-right shunts, particularly ventricular septal defects, may develop severe symptomatology in the first year of life. The early mortality in this group has frequently been reported as high. For example, Keith reporting a series of 111 symptomatic infants with ventricular septal defect in 1956 noted that a third or more of these patients died in the first year of life.[1] Earlier, Marquis had claimed that ventricular septal defect was the most common cause of death from congenital heart disease among children three years of age or less.[2]

In 1960, ten of 17 patients with ventricular septal defect complicated by congestive failure were reported by Morgan to have died within the first year of life.[3] A significant infant mortality has been reported to attend patent ductus arteriosus[4] and even atrial septal defect.[5] With the possible exception of an uncomplicated atrial septal defect, it is generally appreciated that left-to-right shunts commonly cause severe growth failure, congestive heart failure, and are frequently associated with pneumonitis to which these infants with abnormally high pulmonary blood flows are so susceptible.

The experience reported in this study reveals that the majority of those patients with left-to-right shunts at any level, *when these shunts are not complicated by severe defects involving other organ systems*, survive on medical therapy. This therapy consists, as it did in the past, of salt restriction, *adequate* digitalization utilizing electrocardiographic evidence of toxicity when this end-point becomes a clinical necessity, mercurial or thiazide diuretics, antibiotic or chemotherapeutic control of infection, and attention to important nursing details such as proper feeding and positioning of the infant.

* * *

IF THERE is anything new in the management of these patients, it is a reorientation as to the frequency and importance of congenital heart disease.

A review of data from a number of sources reveals that approximately six babies in 1,000 live births are born with congenital heart disease.[6] Furthermore, it is being increasingly appreciated that congenital heart disease commonly causes congestive failure in the first year of life. This awareness, coupled with the knowledge that in early infancy congestive failure and its precipitating cardiac lesion may lurk behind any severe respiratory tract infection or respiratory distress syndrome, has led to a commendable increase in the antemortem diagnosis of congenital heart disease in these infants. This earlier diagnosis has led to a more prompt institution of medical therapy with a predictable increase in survival.

The validity of surgical therapy for these defects in infancy has been based in part on outdated medical data such as that mentioned earlier in the discussion. Excluding infants with patent ductus arteriosus, it is the exceptional patient who, in congestive failure from an uncomplicated left-to-right shunt, requires more than early and aggressive medical therapy.

* * *

WHEN SURGERY is required, banding of the pulmonary artery[7] is the preferred procedure in this institution unless the left-to-right shunt is due to a patent ductus arteriosus, in which case the ductus is ligated. The preference for pulmonary artery banding over closure of an intracardiac defect utilizing cardio-pulmonary by-pass is *based on the absence of any practical limitation in terms of weight or age for the banding procedure.* It is further based on findings enumerated in this report, wherein only three of 62 cases of ventricular septal defect (including two of the infants banded) could be considered as candidates for pump surgery in infancy; that is, older than six months of age and weighing 4.5 kilograms or more.

Pulmonary banding is an undesirable procedure because of uncertainty as to the adequacy of the pulmonary artery constriction, the palliative nature

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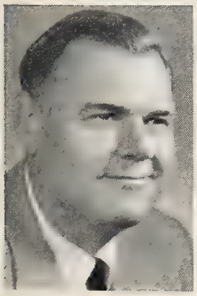
COMING TO ADDRESS CENTENNIAL

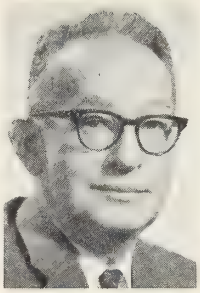
Paul Kabler, M.D., Acting Deputy Chief, Basic and Applied Science Branch, Division of Water Supply and Pollution Control, Robert A. Taft Engineering Center, Public Health Service, Cincinnati, who will discuss "Detergents and Their Relations to Private and Public Water Supplies," Friday, September 24, at the 9:30 a.m. general assembly.



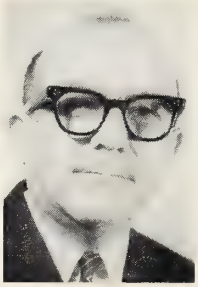
Malcolm A. McCannel, M.D., Clinical Assistant Professor of Ophthalmology, University of Minnesota Medical School, who will discuss "The Family Doctor and His Problem Eye Cases," Wednesday, September 22, at the 12:30 p.m. scientific luncheon-meeting sponsored by the MSMS Section on General Practice and open to all registrants.

Lawrence K. Pickett, M.D., Professor of Surgery and Pediatrics, Yale University School of Medicine, who will discuss "Surgical Views on Neonatal Jaundice," Thursday, September 23, at the 12:30 p.m. scientific luncheon-meeting sponsored by the MSMS Section on Pediatrics and open to all registrants.

Adolph Rostenberg, Jr., M.D., Head of the Department of Dermatology, University of Illinois College of Medicine, who will discuss "Drug Reaction," Wednesday, September 22 at the 12:30 p.m. scientific luncheon-meeting sponsored by the MSMS Section on Dermatology and open to all registrants.



Edward A. Gall, M.D., Professor of Pathology, University of Cincinnati College of Medicine, who will discuss "Wither Pathology?" Thursday, September 23, at the 12:30 p.m. scientific luncheon-meeting sponsored by the MSMS Section on Pathology and open to all registrants.



Harold G. Jacobson, M.D., Chief, Division of Diagnostic Radiology, Montefiore Hospital and Medical Center, Bronx, New York, who will discuss "Roentgen Findings of Some Neurosurgical Abnormalities In Childhood," Thursday, September 23, at the 12:30 p.m. scientific luncheon-meeting sponsored by the MSMS Section on Radiology and Detroit Roentgen Ray and Radium Society and open to all registrants.

of the operation, and the hazard of reconstructing the pulmonary artery. It may, however, be a lifesaving operation.

While pulmonary artery banding is a palliative procedure, it sustains the patient until size and weight enabling the infant to withstand a definitive correction have been achieved. It has been demonstrated that at this point the pulmonary artery constriction can be successfully corrected and the intracardiac lesion closed.[8] The 77 per cent (seven of nine) survival at this institution is representative of that reported.

Although an open heart approach provides for definitive closure in infancy, the risk is exorbitantly high[9] in babies under six months of age. While the overall mortality rate of 70 per cent[10] initially reported has been considerably improved upon, the procedure, to be done *with reasonable safety*, must be limited to children over six months of age or at least more than 4 kilograms.[11,12]

Lillehei's group[13] has also shown that the risk of open heart surgery in infants is enhanced by increasing pulmonary pressures (40 per cent mortality in ten infants with ventricular septal defects and pulmonary hypertension greater than 60 mm. of Mercury). In this regard it should be noted that the presence of pulmonary hypertension in itself is neither an indication for banding nor direct repair, since it has been shown repeatedly that progression of pulmonary hypertension and pulmonary vascular changes is not necessarily a significant problem in the pediatric age group.[14,15]

* * *

THE MANAGEMENT of coarctation of the aorta in infancy remains a controversial subject, because refractoriness to medical therapy is common in this group and the current surgical risk is high. The surgical mortality rate ranges from 34 per cent[13] to 50 per cent.[16] Freundlich *et al*,[18] however, found the medical risk to be similar in that 11 of 27 patients with this lesion expired in the first year of life on medical management. However, all three patients operated in this latter group expired. Both the medical and surgical experience is more difficult with the preductal type of coarctation of the aorta. This in the past has been explained on the basis of inadequate intrauterine development of collateral circulation. An equally plausible explanation is that 40 per cent of the cases with preductal coarctation have associated major cardiac anomalies, while the incidence is 14 per cent in the post-ductal cases.[18]

Certainly, the vast majority of cases dying within the first year of life, whether treatment was medical or surgical, have associated lesions, particularly ventricular septal defects.[13,17,18]

Of the four operated cases in this series, two had preductal coarctations, both with associated ventricular septal defects and one with a hypoplastic left heart complex. A third case had an associated patent ductus arteriosus and the fourth an atrial septal defect accommodating a rather sizable left-to-right shunt. Both of the latter had post-ductal coarctations. In all, surgery was withheld until intensive medical therapy had failed. Two of the four cases, all of whom were operated within the first six months of life, survived.

Of the 12 cases with coarctation treated medically, there was a total of six deaths. Excluding those cases associated with multiple congenital anomalies there were three deaths: two in the first month of life, and the other at seven months of age. Moreover, the three dying with complicating lesions all did so within the first 27 days of life. This represents an improved medical salvage as compared to previous reports.[17]

While patients with patent ductus arteriosus in this age group may respond satisfactorily to medical therapy, experience larger than that reported here shows that a proportion of infants with patent ductus arteriosus, even though adequately treated, may die suddenly from infection or recurrent precipitous congestive heart failure. It is therefore our practice to electively correct this particular lesion after cardiac compensation has been as rapidly restored as possible.

* * *

IT IS NOT IMPLIED that *neonatal* deaths from patent ductus arteriosus or coarctation of the aorta are unavoidable and that, therefore, these patients are not worthy of consideration as candidates for an aggressive medical and surgical effort; nor should one excuse a medical death in newborns with multiple congenital defects. This is the period of peak mortality from congenital heart disease and requires a more aggressive approach than has been evident in the past.

Finally the number of patients in this report is not large, and medical versus surgical treatment at any institution is often contingent on the experience of the pediatrician or surgeon and on the anticipated risks involved. The data herein, while certainly influenced by this type of bias, is nevertheless reported as an institutional observation in hopes that the accumulation and comparison of such data will result in a more rational management of heart disease in infancy.

Summary and Conclusions

The experience reported in this study indicates that basing surgical treatment of the seriously ill, acyanotic infant with congenital heart disease on previously reported medical experience is, at least in this institution, currently invalid. Specifically, the medical management and survival of infants with uncomplicated left-to-right shunts or coarctation of the aorta, has improved significantly in the last several years. Since, with the exception of the thiazide diuretics, there has been little change in the medical armamentarium, it is assumed that this improved medical salvage is largely based upon a better orientation as to the prevalence and significance of congenital heart disease and the fact that it is frequently marked by respiratory tract infection or growth failure.

The resultant increased pediatric activity in the cardiologic area has effected a greater medical salvage.

This position is consistent with the necessity of surgical therapy for the infant with congenital heart disease who has not adequately responded to medical management. In the experience reported herein, this means that a minority of those cases with ventricular septal defects and coarctation of the aorta suffering from congestive failure, growth failure, or both, require surgery (pulmonary banding or resection of coarctation). The majority of cases with patent ductus arteriosus presenting with significant difficulty within the first year of age are operated upon, but this is a select group for whom surgical correction presents a relatively negligible hazard.

Open heart surgery requiring the use of extracorporeal circulation has not been used in the patient population considered in this study for two reasons: First, the majority of those patients requiring surgery, particularly those with ventricular septal defects, do so within the first six months of life before the infant has achieved a weight of 4.5 kilograms when the risk of pump surgery is prohibitive; and secondly there has been only one of 62 infants with ventricular septal defects admitted within the first year of life in the last three years dying in the operable age or weight range (two infants over six months of age were banded).

Improved management of the seriously ill infant with correctable acyanotic heart disease requires that the necessity for surgical intervention in the first year of life be reassessed in terms of more current medical experience. Until this has been accomplished, a plea is made for a more aggressive and sustained medical effort. This is based on the observation in this study that of the 80 infants with *uncomplicated* systemic-pulmonary circuit communications and the nine with uncomplicated coarctation of the aorta, 72 of the former and six of the latter, survived the first year of life on early and adequate medical therapy.

Because the medical and surgical mortality remains high in those becoming ill in early infancy and in those with multiple cardiovascular malformations, it is to these that intensified diagnostic and therapeutic efforts must be directed. While this is the period of peak mortality from congenital heart disease, this outcome should not be considered inevitable.

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AMA Clinical Convention
Philadelphia, Pennsylvania
Nov. 28-Dec. 1

Felty's Syndrome is rheumatoid arthritis with neutropenia and splenomegaly. Two patients with Felty's Syndrome are described who did not have the articular findings of rheumatoid arthritis, but in whom the diagnosis of rheumatoid disease was established by biopsy of a nodule and the presence of rheumatoid factor. Splenectomy remains the preferred treatment when complications of the hematological manifestations of Felty's Syndrome are present.

Felty's Syndrome

A REPORT OF TWO UNUSUAL CASES

By GILBERT J. GALENS, M.D.
BIRMINGHAM

Felty's Syndrome is a variant of rheumatoid arthritis characterized by peripheral symmetrical chronic synovitis, splenomegaly, neutropenia and myeloid hyperplasia with impaired granulopoiesis. Although it is an uncommon disorder, it is potentially a serious one. It is frequently associated with chronic and recurrent pyogenic infections that cannot be controlled with antibiotics and that may be life threatening.

Because Felty's Syndrome is a form of neutropenia that can be corrected by splenectomy, in contrast to drug induced neutropenia, myelofribrosis or bone marrow replacement by tumor or granuloma, establishing this diagnosis is of more than academic interest.

Fortunately, in most cases the characteristic clinical and laboratory findings are present and the diagnosis of Felty's Syndrome can be readily made.

The present report was prompted by the recognition of Felty's Syndrome in two patients in whom the diagnosis was not initially apparent. Neither patient had recognizable rheumatoid joint involvement when seen for their hematological disease. Both patients had a history of bacterial infections, as well as severe neutropenia, and a greatly enlarged spleen. Subcutaneous nodules that were histologically characteristic of rheumatoid disease and a positive test for rheumatoid factor eventually helped establish the diagnosis. The importance of recognizing the etiology of a patient's neutropenia is again stressed, for both the type of treatment and the prognosis are contingent upon the basic diagnosis.

It is one purpose of this report to call attention to the fact that rheumatoid disease can be manifested in a patient primarily as a hematologic disorder and that clinically apparent rheumatoid joint involvement may be absent.

Case Reports

C. H. (U.M.H. #652047), a 61-year-old white male, was first seen at the University of Michigan Hospital December of 1948. During the previous year he had been treated on two occasions for anemia and pneumonia. Splenomegaly had also been noted. Episodic attacks of migratory joint pain had occurred since 1944 but swelling, heat or redness of the involved joints were not noted by the patient. Physical examination confirmed the presence of splenomegaly, the lower pole descending to the level of the umbilicus with inspiration. Hepatomegaly was not noted.

Several examinations of the peripheral joints by the ward physicians and the senior rheumatological consultant revealed no evidence of rheumatoid joint disease, although a small subcutaneous nodule on a finger was noted. Laboratory studies revealed only minimal anemia with a hemoglobin of 12.5 grams per 100 ml. However, the white blood count was 1,500 cells per cubic millimeter with 4 per cent neutrophils. The serum albumin was 4.4 grams per 100 ml. and the globulin was 4.7 grams per 100 ml. Liver function studies were normal. Bone marrow examination revealed active erythropoiesis. Granulopoiesis was apparently unimpaired. Late myelocytes were predominant although seg-

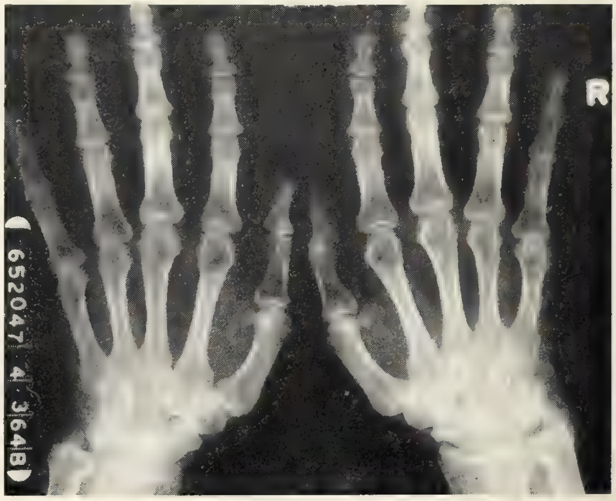

Figure 1. C.H. X-ray of the hands and wrists. Minimal erosive changes are present in the right ulnar styloid, right first metacarpophalangeal joint and possibly in the metacarpal heads of both index fingers. These erosions are suggestive of rheumatoid arthritis.

Formerly Teaching Associate, Department of Internal Medicine, The University of Michigan Medical School and Fellow, Rackham Arthritis Research Unit.

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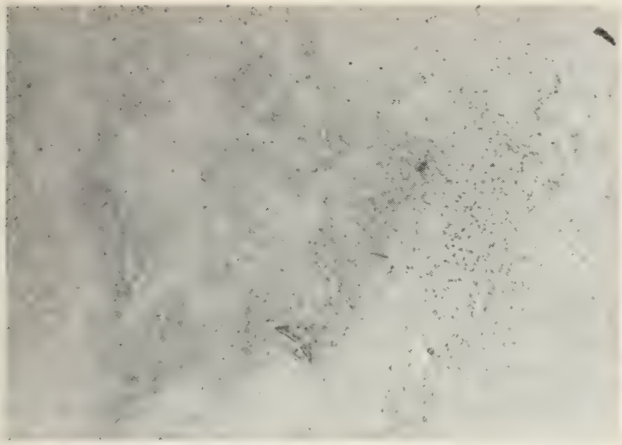


Figure 2. C.H. Section of subcutaneous nodule from left forearm, H and E stain. Coalescent areas of fibroid necrosis are bordered by histiocytes and fibrous connective tissue. The findings are characteristic of the subcutaneous nodules associated with rheumatoid arthritis.

mented forms were present. Roentgenograms of the hands and wrists were interpreted as negative.

Splenectomy was advised and performed in 1949. The spleen measured 21 x 16 x 8 centimeters and weighed 1,220 grams. The pathological examination did not reveal evidence of systemic lupus erythematosus, infiltrative disease, or myeloid metaplasia. The white blood count rose from 2,100 cells per cubic millimeter preoperatively to 6,600 cells per cubic millimeter two hours after splenectomy.

The patient was next seen in April, 1964, with complaints of anemia and hypertension. He had continued to have pain in several joints following physical activity. He also reported that nodules had been present intermittently. Morning stiffness and joint swelling had not been noted. Physical examination again failed to indicate evidence of rheumatoid joint disease. Bony swelling of the proximal and distal interphalangeal joints, slight ulnar drift, a mild flexion contracture of the elbows, and minimal decrease in subtalar motion were present and felt clinically to be compatible with degenerative arthritis. Subcutaneous nodules on the extensor surfaces of both forearms were present on admission. A nodule on the left third finger developed while he was in the hospital.

The hemoglobin was 8.7 grams per 100 ml., the hematocrit 31 per cent and the white blood count 9,700 cells per cubic millimeter. The differential count revealed 20 per cent neutrophils, 55 per cent lymphocytes, 23 per cent monocytes, 1 per cent eosinophils, and 1 per cent basophils. The latex fixation test for the rheumatoid factor was positive in a dilution of 1:160. A direct Coomb's test was weakly positive and cold autohemagglutinins were present in a dilution of 1:4. Total serum proteins were 8.2 grams per 100 ml. Electrophoretic fractionation indicated 42 per cent albumin, 4.0 per cent alpha-1 globulin, 5.6 per cent alpha-2 globulin, 19.3 per cent beta globulin and 27 per cent gammaglobulin. No abnormal globulin peaks were present. A lupus erythematosus cell preparation was negative. Roentgenograms of the hands and wrists revealed minimal erosive lesions in a distribution suggestive of rheumatoid arthritis. A Schirmer's test indicated almost complete absence of tear formation, although corneal staining was absent. A biopsy of the subcutaneous nodule disclosed changes characteristic of the nodules found in rheumatoid disease.

A careful clinical evaluation of the anemia was carried out that included serum iron determinations, upper and lower gastrointestinal x-ray examinations, sigmoidoscopy, and other appropriate studies. The anemia was found to be secondary to iron deficiency (serum iron 22 micrograms per 100 cc.). No gastrointestinal lesion other than a small polyp in the sigmoid colon was demonstrable. Microscopically this proved to be a benign adenoma. The anemia subsequently responded well to oral iron therapy, the hematocrit rising from 31 per cent to 42 per cent in two months. The source of the iron loss was not established. Serial blood pressure readings varied from 170/110 to 150/90. This was felt to represent mild essential hypertension.

Comment

A 61-year-old male with a 20-year history of arthralgia and recurrent subcutaneous nodules had a splenectomy early in the course of his illness for severe neutropenia in the presence of moderate splenomegaly and a cellular bone marrow. Clinical examinations repeatedly failed to reveal evidence of rheumatoid joint involvement. The diagnosis of rheumatoid disease was established, however, by the biopsy of a subcutaneous nodule, the presence of rheumatoid factor, and roentgenograms of the hands and wrists. In retrospect, the diagnosis of Felty's Syndrome is apparent.

* * *

C. W. (U.M.H. #205458), a 74-year-old male, was first seen at the University of Michigan Hospital in February of 1962 because of a low white blood count and splenomegaly. Joint disease first occurred at the age of 20 years. Acute synovitis characterized by pain, swelling and warmth was present in the hands, shoulders, knees, ankles, and heels. Severe episodes recurred in these joints over the next two years and mild joint pains were noted for the following 12 years. After the age of 34 he experienced no further symptoms of arthritis.

At the age of 34 asymptomatic splenomegaly was first noted by the patient's physician. Small subcutaneous nodules had been intermittently present on his hands for several years. In 1958 one of these was excised from his left thumb. In 1961 he had been treated for a pyogenic infection of the left foot at which time a low white blood count and splenomegaly were noted. He subsequently complained of vague abdominal pain and ease of bruising. Recurrent skin infection, persistent otitis, and a 30-pound weight loss prompted admission to the hospital. Physical examination disclosed an enlarged liver that descended 8 cm. below the right costal margin and an enlarged spleen palpated 17 cm. below the left costal margin. Bony swelling was noted in the terminal interphalangeal joints of several fingers, the left fifth proximal interphalangeal joint, and the left ankle. Motion was limited in the left ankle. The left ankle and several fingers had been injured many years previously. No synovial swelling or joint effusions were present. The joint examination indicated traumatic arthritis and osteoarthritis.

The hemoglobin was 11.9 grams per 100 ml., the hematocrit 39 per cent, and the white blood count 800 cells per cubic millimeter. The differential count revealed 12 per cent neutrophils, 56 per cent lymphocytes and 32 per cent monocytes. Moderate rouleaux formation was noted. The platelet count was 55,000 per cubic millimeter. The total serum protein was 7.6 grams per 100 ml. Fractionation by electrophoresis disclosed 42 per cent albumin, 2.9 per cent alpha-1 globulin, 6.9 per cent alpha-2 globulin, 6.9 per cent beta globulin and 37 per cent gamma globulin. No pathological globulin peaks were noted. A latex fixation test

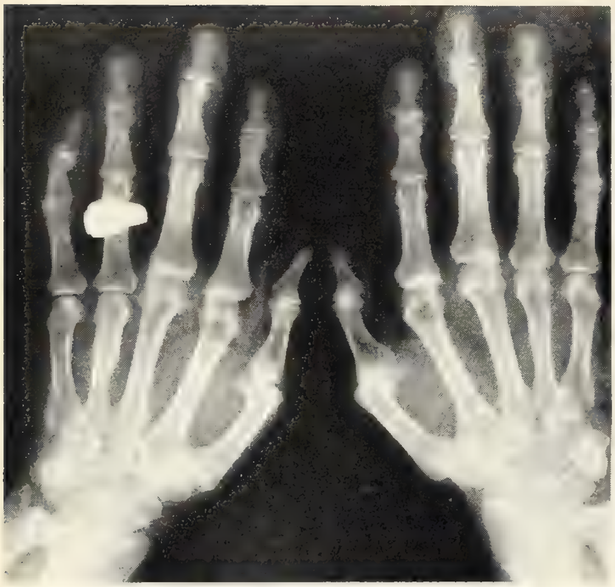


Figure 3. C.W. X-ray of the hands and wrists. Degenerative changes are present in the terminal interphalangeal and second and third metacarpophalangeal joints. Subchondral sclerosis and hypertrophic lipping are noted. These changes are indicative of osteoarthritis.

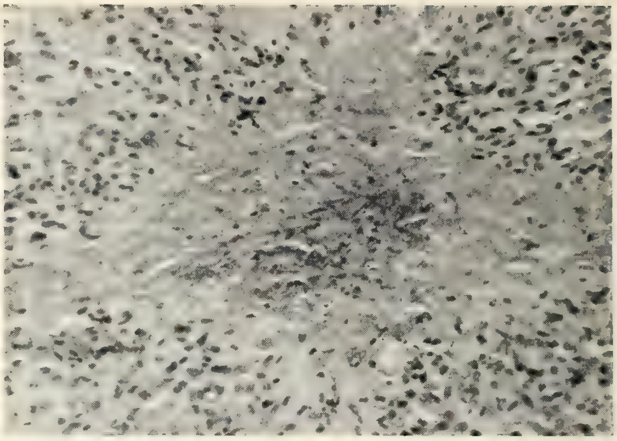


Figure 4. C.W. Biopsy of subcutaneous nodule from a finger, H and E stain. The central area of fibrinoid necrosis is encompassed by histocytes arranged in a palisade and granulomatous inflammatory tissue. The changes are characteristic of the subcutaneous nodules present in rheumatoid arthritis.

was positive at a dilution of 1:5120. A lupus erythematosus cell preparation was negative. The serum glutamic oxalacetic transaminase, alkaline phosphatase, and bilirubin were normal. A sternal marrow aspiration revealed a cellular specimen. Erythopoiesis was normoblastic. Megakaryocytes were abundant although budding was decreased. Increased numbers of progranulocytes and plentiful band forms were present, but a marked decrease was noted in the number of segmented neutrophils. Roentgenograms of the hands and wrists revealed evidence of degenerative arthritis. Changes indicative of rheumatoid arthritis were not present. Pathological review of the subcutaneous nodule excised in 1958 revealed findings characteristic of the nodules found in rheumatoid arthritis.

Splenectomy was performed. The spleen measured 20 x 25 x 15 cm. and weighed 1,665 grams. Pathological examination disclosed stromal hyperplasia. No evidence of systemic lupus erythematosus or other specific disease was present. An immediate rise of the white blood count to 7,550 cells per cubic millimeter and of the platelets to 140,000 per cubic millimeter occurred postoperatively. One month later the white blood count was 5,300 cells per cubic millimeter with 13 per cent neutrophils, 16 per cent monocytes, 69 per cent lymphocytes, 1 per cent eosinophils and 2 per cent basophils.

No recurrence of infectious disease and no joint symptoms were noted by the patient when last seen in August, 1964. Physical examination revealed a small nodule in proximity to the flexor tendon of the right thumb but no evidence of rheumatoid joint disease. The hemoglobin was 16.4 grams per 100 ml. and the hematocrit 49 per cent. The white blood count was 12,100 cells per cubic millimeter with a differential count of 54 per cent neutrophils, 29 per cent lymphocytes, 13 per cent monocytes, 3 per cent eosinophils and 2 per cent myelocytes.

Comment

This patient had symptoms of rheumatoid disease beginning 54 years previously. The rheumatoid disease was documented by the finding of a typical subcutaneous nodule and the presence of rheumatoid factor in the serum. Serious neutropenia with marked splenomegaly developed as a manifestation of the rheumatoid disease, yet joint findings of rheumatoid arthritis were not present.

Historical Background

The involvement of hematopoietic and lymphoid tissue by the rheumatoid process was first formally noted in 1896 by Chauffard and Ramon,[1] who described the combination of lymphadenopathy, splenomegaly, and arthritis in adults. Shortly thereafter, Still remarked upon the presence of splenomegaly and adenopathy in children with rheumatoid arthritis.[2] In 1908 von Jaksch reported finding leukopenia in association with splenomegaly and arthritis.[3]

It remained for Felty[4] to bring these associations to the attention of the American medical community. In 1924, he described five patients with the triad of chronic arthritis, splenomegaly, and leukopenia which has subsequently come to be recognized as Felty's Syndrome. He also pointed out that hyperpigmentation, weight loss, and lymphadenopathy were frequent findings in this disorder. He concluded that the pathological process was probably caused by a noxa that simultaneously affected the joints, the spleen and the white blood cells.

Discussion

As knowledge in the field of connective tissue diseases has expanded, rheumatoid arthritis has been found to involve many organ systems. Felty's

Syndrome is a variant of rheumatoid disease with prominent hematological manifestations. Although it is not a common disorder—Short, Bauer, and Reynolds recognized only three cases in 293 patients with rheumatoid arthritis followed for a 20-year period[5]—it is of particular importance because of the septic complications that can develop. A low total white blood count is usually seen, but a selective *neutropenia* is the characteristic feature of Felty's syndrome. Thrombocytopenia can occur but infrequently is severe enough to be responsible for bleeding manifestations. A normocytic anemia is often present as a manifestation of the rheumatoid disease and is usually unrelated to hypersplenism. However, hemolytic anemia has been described as a manifestation of Felty's Syndrome. Normal or increased cellularity with defective granulopoiesis and a relative paucity of mature neutrophils are the findings seen on bone marrow examination.

Recent reports implicate a circulating substance in the pathogenesis of the hematological abnormalities. Tullis[6] found leukoagglutinins in 70 patients with leukopenia associated with a cellular marrow. Three of these patients had Felty's Syndrome. Calabresi, Edwards and Schilling[7] using a fluorescent antiglobulin technique showed that gamma globulin was attached to leukocytes in patients with systemic lupus erythematosus and in patients with Felty's Syndrome. Sera from two of the patients with Felty's Syndrome produced fever and leukopenia upon injection into normal subjects.

The hematological manifestations of Felty's Syndrome are usually noted late in the course of the arthritis, but occasionally appear shortly after the onset of joint disease and rarely may precede the onset of arthritis. No relationship appears to exist between the severity of the peripheral joint disease and the degree of neutropenia. Synovitis may be mild and relatively inactive or may be severe and associated with marked destructive changes. In all previously reported cases peripheral joint findings have been clearly present. Hepatomegaly with normal liver function studies, lymphadenopathy, hyperpigmentation of the skin, and chronic ulcerations of the legs are other features sometimes noted in Felty's Syndrome. Splenomegaly is generally not marked, but massively enlarged spleens have been described.

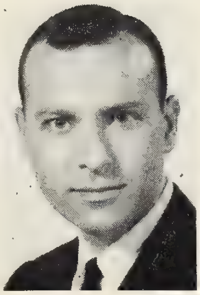
Primary splenic neutropenia is an entity characterized by a hyperplastic bone marrow, granulocytopenia, and splenomegaly. It is not associated with inflammatory joint disease, subcutaneous nodules, or other manifestations of rheumatoid disease and thus would not ordinarily be confused with Felty's Syndrome. Of interest, though, is the observation that some patients with primary splenic neutropenia have severe arthralgias.[8] One could speculate regarding the relationship of patients with arthralgias and primary splenic neutropenia and the patients in this report, but more information would be needed to associate rheumatoid arthritis with primary splenic neutropenia.

To the author's knowledge no previous case has been reported with rheumatoid disease and Felty's Syndrome but without clearly recognizable joint involvement. A possible exception is the report of a 63-year-old female with subcutaneous nodules, diagnosed as granuloma annulare, and with thrombocytopenic purpura that was corrected by splenectomy.[9] Detailed information was not reported in this case. Granuloma annulare histologically may be indistinguishable from the nodules of rheumatoid arthritis, but no data is available concerning the presence or absence of joint findings, bone marrow examination, or the subsequent course of the patient. It is not reasonable to implicate rheumatoid disease in this case on the basis of available data.

The presence of neutropenia and splenomegaly in the absence of rheumatoid joint disease may present some difficulty in diagnosis. Cirrhosis of the liver, myeloproliferative disorders, and reticuloendothelial malignancies are the most common entities to be considered. Careful clinical evaluation and appropriate laboratory studies should lead to the proper diagnosis and treatment. The cases reported here are of interest because of the recognition of persistent rheumatoid disease without the clear-cut presence of joint involvement. They are also of importance in pointing to a need to consider the diagnosis of Felty's Syndrome in a patient with a hematological disorder even when rheumatoid arthritis is not apparent, because of the therapeutic implications. In these unusual cases, the diagnosis of rheumatoid disease might be suggested by the presence of a characteristic nodule or of rheumatoid factor in the serum.

Treatment

The therapy of rheumatoid joint disease in a patient with Felty's Syndrome is essentially the



THE AUTHOR

Gilbert J. Galens, M.D.

same as it would be in uncomplicated rheumatoid arthritis. Treatment of the hematological aspects of the syndrome has not proven to alter the symptoms or the course of the arthritis. If the neutropenia or thrombocytopenia is not associated with the presence of recurrent or chronic infection or with purpura, no treatment is indicated. When clinical manifestations of the hematological abnormalities are present definitive treatment is indicated, for a spontaneous remission is unlikely to occur. Adrenal corticosteroids are associated with only temporary improvement in the blood values and, therefore, are not used as definitive treatment. They are useful, however, in preparing a patient for splenectomy. Generally 200 mg. of hydrocortisone daily or its equivalent is used for several days preoperatively. This may allow better control of pre-existing suppurative or hemorrhagic conditions.

Splenectomy is the treatment of choice. Improvement in the number of circulating granulocytes often is seen within hours after the operation but at times may not occur for several days. Generally the improvement is maintained, but occasionally the total white blood count or the total number of neutrophils may again decrease. Not infrequently the total white blood count may remain normal but the percentage of granulocytes will fall. Should this occur the total neutrophil count usually remains higher than the preoperative values, and the patient is still better able to cope with bacterial infections.

Summary

Two cases have been presented with rheumatoid disease complicated by Felty's Syndrome. Neither patient had peripheral joint findings generally associated with rheumatoid arthritis. The diagnosis of rheumatoid disease was confirmed in both patients by the presence of characteristic changes in a subcutaneous nodule and the presence of rheumatoid factor. One patient had findings suggestive of rheumatoid arthritis in the roentgenograms of his hands and wrists. The importance of establishing the pathogenesis of neutropenia, anemia, or thrombocytopenia has been stressed because the treatment and prognosis is dependent upon the diagnosis. The interesting occurrence of rheumatoid disease without chronic joint manifestations has not, to the author's knowledge, been previously reported.

(Acknowledgment: The author would like to acknowledge the aid and encouragement received from Giles G. Bole, Jr., M.D., in the preparation of this paper.)

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CENTENNIAL SESSION

Michigan State Medical Society
Detroit Cobo Hall & Sheraton Cadillac

Sept. 19—Medicine and Religion Day
Sept. 20—Medicine and Business, Industry and Communications Day
Sept. 21—Medicine and Medical Organization Day
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PLAN TO ATTEND

The Paper Jungle

To a member of the clinical research staff of a pharmaceutical manufacturer the impact of the new drug law and F.D.A. regulations has been overwhelming. The immediate and unprinted reaction reflects the enormous increase in paper work and the infinite detail that are now demanded of the individual responsible for the clinical development of a drug for a pharmaceutical manufacturer. . . . You have all been regaled by accounts of the size of the current new drug applications. Our latest weighed 550 pounds, and is by no means a record. Sending in supplementary case data on that particular application involved reproducing, collating and forwarding over 80,000 individual sheets of paper!—Irwin C. Winter, Ph.D., M.D., in *Journal of New Drugs,* 4:6, (Nov.-Dec.) 1964.

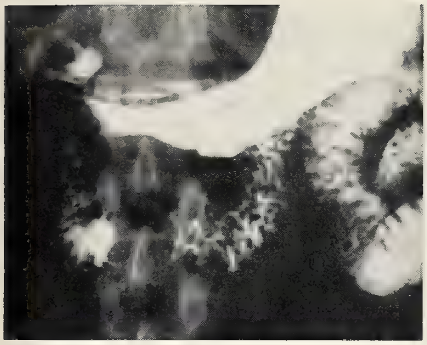

Figure 1. Sharply defined round, filling defect overlying the spine.

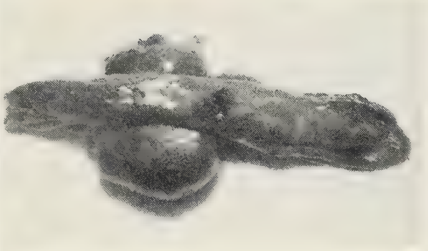

Figure 2. Case No. 1. 2.5 cm. tumor protruding on both serosal and mucosal side with ulceration of mucosa.

Figure 3. Original magnification 100x. Interlacing bundles of smooth muscle fibers, no mitoses.

Leiomyomas of the Duodenum

BY
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BOTH OF IRON MOUNTAIN

Leiomyomas of the duodenum are infrequently reported, though leiomyomata of the stomach are not uncommon and similar neoplasms are occasionally observed in the small intestine. Because leiomyomas may be the source of severe gastrointestinal hemorrhage, may undergo malignant degeneration, are difficult to detect radiographically, but are not infrequently seen at necropsy, it is apparent that an increased clinical awareness is mandatory. Undoubtedly, many reports of cases repose in record rooms, and many more are not clinically diagnosed.

Prior Reports

The first report of a leiomyoma of the duodenum was by Hoffmeister in 1935.[3] There have been excellent reviews by Olson, Dockerty and Gray[9] in 1951; Oberhelman, Condon and Guzauskas,[8] and Straus and O'Dane[12] in 1952; Keifer and Christiansen[5] in 1956; and Knoernschild and Kelley[6] in 1962. Mittelpunkt, Capos and Bernstein[7] in 1964, were able to collect 46 cases from the world literature and added three additional cases. The danger of hemorrhage from leiomyomas was emphasized by Butler[1] in 1959 and Huntby, Laurain and Stevenson[4] in 1960, and the danger of malignant degeneration was emphasized by Starr and Dockerty[11] in 1955.

Symptoms

Since many benign tumors of the duodenum are first noted as incidental findings at necropsy, it is apparent that symptoms are usually vague or nonexistent. Sensations of epigastric fullness or persistent mild intestinal discomfort may bring the patient to the physician, but the usual presenting problem is a painless, sudden and severe hemorrhage. River, Silverstein and Tope[10] observed that significant bleeding occurred in one-third of reported cases; and that usually the patients were treated with transfusion, diet and hematinics, and discharged with an incorrect diagnosis.

Diagnosis

A high index of suspicion in the minds of both the clinician and the roentgenologist is apparently necessary for diagnosis. It may be necessary to have the radiologist repeatedly examine the patient and use special techniques to demonstrate the lesion. Pre-operative diagnosis depends on roentgenographic visualization. Buxton[2] has stated that the roentgenologist is more apt to make the correct diagnosis than the clinician.

In the patient undergoing exploratory laparo-

Abstract—Leiomyomas of the duodenum must be suspected in the patient with massive or recurrent gastrointestinal hemorrhage with absent clinical or roentgenographic findings. Careful, repeated roentgenographic study is necessary. Surgical removal is indicated when the lesion is diagnosed, as fatalities from hemorrhage and from malignant degeneration have been reported.

E. Theodore Palm, M.D., The Swedish Hospital, Minneapolis, Minnesota; Ralph E. Carlson, M.D., Memorial Hospital, Iron Mountain, Michigan; Donald T. Anderson, M.D., Memorial Hospital, Iron Mountain, Michigan.

tomy for gastrointestinal hemorrhage, it is obvious that a very careful palpation of the entire bowel and duodenum between the fingers is mandatory. The size of the hemmorhage does not reflect the size of the lesion, and the tumor may be missed on routine abdominal exploration.

Case Reports

Case No. 1

A 37-year-old white female was admitted to the hospital on November 6, 1961, complaining of feeling faint and being weak and dizzy. She had noted that her stools had been black for two days, but had no pain or abdominal discomfort. She was obviously pale, her hemoglobin was 6 grams per 100 cc. of blood.

Two years previously she had undergone cholecystectomy for cholelithiasis. For the past six months she had been on a weight reduction program and had lost 20 pounds.

An upper gastrointestinal series revealed no evidence of pathology in the stomach, but it was noted that there was a thickening of the mucosal pattern of the duodenum and that there was minimal deformity of the bulb. The patient was transfused, given anticholinergics and a bland diet. Six days after admission there was no evidence of blood in the stools. Roentgenographic study was repeated after ten days of treatment and again no abnormal changes other than constant minimal deformity of the bulb was reported. She was discharged from the hospital with a diagnosis of a bleeding duodenal ulcer; she was advised to take anticholinergics, ferrous sulfate and stay on a liberal bland diet.

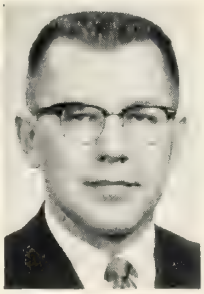
She continued to feel well, her hemoglobin remained normal, and she could eat all types of food without distress. However, on August 30, 1962, she came to the office and reported that she had passed a large tarry stool. She had no pain, her only symptom was weakness. Her hemoglobin was 8.2 grams. Roentgen examination revealed only minimal duodenal deformity and she responded to transfusion and conservative management and was again discharged from the hospital.

A follow-up upper gastrointestinal series was done one month later. On this examination a variation of the mucosal pattern was noted in the transverse portion of the duodenum. The original impression was that the defect was due to extrinsic pressure of the spine as the defect occurred in the midline; but the possibility of an intramural lesion, such as a leiomyoma, was entertained. The study was then repeated, with multiple spot radiographs of the transverse portion of the duodenum. On these films a sharply defined, rounded filling defect could be seen (Fig. 1). In retrospect, a defect in the same area could be noted on the films taken on the first admission.

Surgical exploration was advised, and a hard, rubbery tumor was found in the transverse portion of the duodenum, lying to the right of the superior mesenteric vessels, and proximal to the ligament of Trietz. By means of the Kocher maneuver, the duodenum was mobilized, and a 10 centimeter portion of the duodenum was excised, and an end-to-end anastomosis of the duodenum performed.

CO-AUTHOR

P. Theodore Palm, M.D.



The tumor was 2.5 cm. in diameter, appeared to be well encapsulated, and protruded in an hour-glass fashion both into the lumen and out on the serosal side (Fig. 2). A small area of ulceration of the mucosal portion could be seen.

On microscopic section (Fig. 3), interlacing bundles of smooth muscle were found, no mitoses were seen, and the tumor had the typical picture of benign leiomyoma.

The patient made an uneventful recovery and was discharged on the ninth postoperative day. She has had no recurrence of symptoms.

Case No. 2

On a routine physical examination of an 86-year-old man, a firm, non-tender, smooth tumor was found. The patient had been aware of the mass for six months, but it caused him no distress. He thought that the mass had enlarged slightly during the past two or three months.

The patient was very slender, and a mass that seemed to be the size and texture of a grapefruit could be palpated in the epigastrium. Physical examination was otherwise unremarkable.

On fluoroscopic examination of the upper gastrointestinal tract, the stomach was found to be normal. The duodenal bulb filled and emptied readily, showing minimal deformity, but without demonstrable crater. The second portion of the duodenum was not unusual, but the third portion was deformed as if by extrinsic pressure, the barium bolus giving the impression of tumbling over a waterfall.

Reviewing some films made during an upper gastrointestinal series done nine years previously, a mass approximately half the present size could be seen in approximately the same location. This was not noted, however, on the original report.

At laparotomy a tumor mass measuring 10 x 15 centimeters was found beneath the peritoneum and apparently arising from the third portion of the duodenum. It was freed from the surrounding structures by blunt and sharp dissection, the duodenum transected on either side of the mass and approximately 13 centimeters of duodenum excised. An end-to-end anastomosis was done and the peritoneum approximated over the duodenum. A large, tense gallbladder with a stone in the cystic duct was also removed.

The tumor and attached duodenum weighed 1200 grams and measured 10 x 13 centimeters, consisting of a firm, nodular mass somewhat resembling uterine myomas. The mucosal layer overlying the tumor was distorted by pressure. There was no gross evidence of invasion of the mucosal or submucosal layers. The tumor apparently arose from the muscular coat.

On microscopic examination, innumerable cystic spaces were found. They contained fluid that varied from a clear, watery yellow to a dark, red bloody material. The stroma was pale, yellow-white, arranged in trabeculae and whorls. No mitotic figures could be found, but there was a moderate degree of nuclear pleomorphism, remarkable in a patient of this age, and suggested a possibly early progression towards malignancy.

The patient did well postoperatively and was discharged from the hospital in nine days. There was no evidence of recurrence and he died from a cerebrovascular accident three years later.

Duodenal leiomyomas arise from the muscular layer of the duodenum. They grow slowly, either in the submucosal or the subserosal layers or both. They may undergo degenerative changes such as necrosis, cavitation, cyst, abscess formation; or may obstruct, perforate or ulcerate and bleed. Starr and Dockerty believe that malignant degeneration may occur.[11] Hemorrhage occurs in a high percentage of cases, and is usually the presenting symptom. Most of the cases reported in the literature have histories extending back from five to 15 years, with repeated episodes of bleeding.

The patient with massive or recurrent gastrointestinal hemorrhage with minimal or absent clinical and roentgenographic findings deserves repeated and careful x-ray studies. Though leiomyomas are benign, fatalities from hemorrhage have been reported.[8] Surgical excision by the simplest method is indicated. Tumors may be discovered on routine physical or radiographic examination; and even though asymptomatic, should be surgically removed.

Summary

1. Leiomyomas of the duodenum are slowly growing tumors that may be asymptomatic until hemorrhage occurs.
2. Diagnosis depends upon clinical suspicion and repeated careful roentgenographic study.
3. Treatment is surgical excision.

The authors wish to thank Earl C. Henrikson, M.D., for permission to report the second case.

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MEDISCENE

Sept. 16-19—American Medical Writers Association, Statler Hilton, Detroit.

Sept. 19-24—MSMS Centennial Session, Cobo Hall and Sheraton Cadillac Hotel, Detroit.
Sept. 19—Medicine and Religion Day
Sept. 20—Medicine and Business, Industry and Communications Day
Sept. 21—Medicine and Medical Organization Day
Sept. 22—Medicine and Science Day
Sept. 23—Medicine and Voluntary Health Day
Sept. 24—Medicine and Government Day

Sept. 21-24—Woman's Auxiliary to Michigan State Medical Society, Ponchartrain Hotel, Detroit.

Sept. 21-24—5th Annual Michigan "Doctors and Wives" Art Exhibit, Cobo Hall, Detroit.

Sept. 22-23—Michigan Medical Assistants Society Annual Meeting, Statler Hilton, Detroit.

Sept. 23—Michigan Health Council Annual Meeting, Cobo Hall, Detroit.

Oct. 20-21—Michigan Tuberculosis & Respiratory Disease Association, Kellogg Center, East Lansing.

Nov. 3—Diabetes Day, Genesee County, Flint.

Nov. 4—Southwestern Michigan Clinic Day, Battle Creek Country Club.

Nov. 7-13—Community Health Week.

Dec. 2—Saginaw Academy of General Practice—Vascular Clinic Day, Bancroft Hotel, Saginaw.

Coming in September

Authors from Sacramento, California, to Boston, Massachusetts, will join in making the September issue well worth your while.

Topics to be covered range from the amalgamation of osteopaths and physicians in California to the treatment of migraine in Massachusetts. Thomas Gahagan, M.D., of the Henry Ford Hospital, reports on replacement of the intrapericardial aorta for dissecting aneurysm. Ralph Ten Have, M.D., of the University of Michigan, presents a thoughtful consideration entitled, "A Preventive Approach to Problems of Child Abuse and Neglect."

Case reports on rupture of the gravid uterus, contact dermatitis from topical steroids, and Agranulocytosis from procaine amide hydrochloride are included, along with a very practical article on a new concept in patient care where abdominal stomal therapy is concerned.

This array of scientific information is complemented by notes on the scalene node and the problem of sarcoidosis by Alfred F. DeGroat, M.D., from the Department of Health Laboratories in Detroit.

This represents a scientific salute to the Michigan State Medical Society on the occasion of its 100th Birthday.

MSMS Centennial Series: 1965

Centennial Session Plans Make Year a Busy One

Leading up to the MSMS Centennial in 1965, THE JOURNAL *is printing a series of articles by William J. Stapleton, Jr., M.D., Detroit, who is the MSMS Historian. This series began in the September, 1963, number of* THE JOURNAL *and will continue through August, 1965.*

Oliver B.
McGillicuddy, M.D.
President, 1964-65

1964-65

Now it is time for Oliver B. McGillicuddy, M.D., to take over as President of the MSMS. His first President's Message in MICHIGAN MEDICINE was "The Election and the Doctor." A most sensible article. He ends up with the question, "Will you be satisfied with your contribution on the morning of November 4?"

The 1964 House of Delegates adopted many resolutions which:

—Urged all component societies to take every possible step to more fully implement the Kerr-Mills (MAA) Law at the local level.

—Reinstituted the annual award of "Michigan's Outstanding Physician" and directed that consideration be given to both professional and civic accomplishments.

—Directed that MSMS continue to work toward the ultimate goal of establishing in Michigan a single medical practice law.

—Strongly urged support of all doctors of medicine of both the Michigan Doctor Political Action Committee and AMPAC.

—Approved federal government subsidization of elderly individuals having limited means in the private purchase of health insurance in the open market, with federally established minimum standards of financial responsibility and of benefits to be met by the involved insurance companies.

—Endorsed in principle the adoption of merit rating by Michigan Medical Service.

* * *

THE SECOND part of the December number gives a "Digest of Proceedings of the 1964 House of Delegates." It is only by reading this report that nondelegates can realize what their brother physicians acting as Delegates do for them. The amount of time, money and energy is tremendous that goes into being a Delegate, serving as President, or as Speaker of the House, serving as a member of The Council, etc.

The year 1964-65 has probably been one of the busiest years of our Society as we prepare to celebrate our 100th Anniversary in September in Detroit. Plans are being made to have a very fine program. The County Societies are all invited to share in this historical event by having, if possible, a story of their own medical history and of their founding. Our Associate MSMS Historian, William M. LeFevre, M.D., has written a booklet entitled "Medical History of Muskegon County." As we stated before, it would be a distinct service to the medical history of our state if each county society followed the example of Muskegon.

* * *

THROUGHOUT 1964-65, the new MSMS Medigram newsletter provided the latest news of what was happening in Washington, Lansing and elsewhere regarding medical matters. A special MSMS Legislative Conference was held in Lansing on state legislative issues facing MSMS. On the federal scene, MSMS worked hard to oppose the Medicare plan of the Johnson administration.

Hugh W. Brenneman, Executive Director, began an interesting monthly "Reporting as Ordered" in MICHIGAN MEDICINE. We congratulate him on what is being done to tell the members about the

The Author
WILLIAM J. STAPLETON, JR.
M.D.
MSMS Historian

work of the Michigan State Medical Society.

February, 1965, provided a sad note for me. Reading the morning paper of the 25th, I noted in the obituary column the death of our old friend, Louis J. Hirschman, who retired some years ago and lived in Traverse City.

Long years ago we were ambulance rivals. L. J. rode a fine underslung ambulance with rubber tires. I rode the Emergency Hospital Ambulance—an old grocery wagon with a top on it. It was painted black and had a big red cross on it. It had a loud gong and when we rattled over the cobble stone streets of old Detroit, it certainly made itself known. Racing to an accident, if there was only one patient, L. J. would always get the case with his beautiful ambulance. If there were more patients than he could take care of, we would get one. If not, we went meekly back to the hospital. On the way, a kid in the street might greet us with a cry of "Slaughter House." Doctor Hirschman was president of Wayne County Medical Society and the Michigan State Medical Society, and he was also a vice president of the American Medical Association. L. J. was beloved by all of us, his fellow physicians and his patients alike. He wrote what I always considered the best composition of its type, "On Treatment of Rectal Diseases," which appeared in many editions. Another good friend has passed on to his reward.

* * *

THE MSMS Postgraduate Medical Education Committee expanded its teaching to 20 programs with several afternoon hospital clinic programs.

MSMS in the spring conducted an extensive Measles Vaccination Program, using billboards, newspapers, radio, television, bus cards, etc.

AUXILIARY SERVES IN MANY WAYS

By Mrs. R. J. Himmelberger, Lansing
President, 1963-64

Editor's Note: Interest has been high in the MSMS historic series by William J. Stapleton, Jr., M.D., and it seemed that physicians would be equally interested in a short history of the Woman's Auxiliary to MSMS.

A history of any State Medical Auxiliary should start with the beginnings of the National Auxiliary. When a medical meeting was held in Oklahoma City, May 15, 1907, 18 doctors' wives accompanied their husbands to this meeting and Mrs. Walter G. Bradford of Shawnee was elected president. This group functioned for eight years. The oldest continuous group was started in South Dakota in 1911. In the thinly populated West these groups helped to relieve loneliness and the need for intelligent women to be active in some wider fields.

Its first public health project was the distribution of the AMA's magazine Hygeia to schools and places where it might contribute to health education, including physicians' offices.

In 1917, the Woman's Auxiliary to the Dallas County Medical Society was formed, their original purpose being stated in the slogan: "Our husbands, our homes, our communities, our country." The following year the Woman's Auxiliary to the Texas State Medical Association was recognized.

In 1922, Mrs. Samuel Clark Red, president of the Texas Auxiliary, petitioned the AMA at its annual meeting in St. Louis to allow them to form a national auxiliary group. The AMA granted the request, noting with canny caution that the proposal did not seem to involve the men in any financial or other form of obligation. The first national president was Mrs. Red.

Today, there are 51 organized auxiliaries which include the District of Columbia and the fifty states. As of June, 1964, there were 87,000 members.

* * *

UNDER THE capable leadership of Dr. Caroline Bartlett Crane of Kalamazoo, Michigan, a group of doctors' wives became known as the Woman's Auxiliary to the Michigan State Medical Society in 1926. History relates that Doctor Crane conceived the idea and our beloved Mrs. Guy L. Kiefer promoted it. It was due to Mrs. Kiefer's determination and her ability to foresee the needs of an auxiliary that gave our organization such a successful beginning.

The auxiliary was formally organized at Mackinac Island on June 26, 1927, by Herbert Randall, M.D., of Flint, Michigan. Mrs. Guy L. Kiefer was elected president and 28 charter members were present.

Shortly after being installed as the first state president, Mrs. Kiefer set about collecting her friends in Detroit with a view to organize the Wayne County doctors' wives. At the organizational meeting, 13 women were present and Mrs. Clarence I. Owen was elected the first president of the Woman's Auxiliary of the Wayne County Medical Society. Within a month or two, 125 doctors' wives were members.

Auxiliaries were organized in other counties immediately.

* * *

FROM THIS SMALL beginning, the auxiliary has expanded to include 43 organized county groups, with two groups in Wayne County and with members-at-large in the unorganized counties.

In 1948, the state membership had grown to such proportions, it was decided that the state should be divided into Districts with a director for each, the directors being elected by the Board.

In June, 1964, the state membership was 3,201, about half of our potential membership.

* * *

THE OBJECTIVES OF our organization are:

1. To promote friendship and understanding among ourselves.

2. To explain the objectives of the medical profession to lay organizations in the matter of health education.

3. To do such work as may be approved or assigned by the Michigan State Medical Society.

* * *

THE WORK OF the Auxiliary is far reaching.

1. The help and money given to needy medical students and to Medical Schools from money donated by the counties to the American Medical Association Education and Research Foundation.

2. Future Nurses Clubs are organized to interest students in a nursing career. Counties award scholarships to medicine, nursing, practical nursing and health careers and loans to nursing and medical students.

3. In the 1962-63 year, an International Health Activities Committee was started by the National Auxiliary and most County Auxiliaries participated collecting thousands of pounds of sample drugs which were sent to World Medical Relief and other organizations. Many thousands of pounds of equipment were also sent to establish small hospitals and clinics all over the world. In the 1963-64 year this committee also worked promoting and helping to sponsor the Women's Division of Project Hope. The Michigan women were asked to organize so as to support and help finance the good Ship Hope.

4. The Mental Health Committee is increasingly active in working with the Michigan State Medical Society, Michigan Society of Neurology and Psychiatry and the Department of Mental Health.

5. The TB and Respiratory Disease Speaking Project has grown from year to year with many students from over the state entering essays from which six are picked to be presented by the student at a radio broadcast on WKAR, the Michigan State University Station.

6. A very active part is taken in working for Legislation favorable to Medicine, and the committee is working closely with the State Medical Society to make all doctors and their wives cognizant of these problems.

* * *

THE HIGH objectives of the founders of the Woman's Auxiliary to the Michigan State Medical Society have always been foremost in our minds. Under the capable leadership of our presidents and their Boards, we have grown in numbers, wisdom and accomplishments.

It has always been and will always be our sincere and earnest desire to be of service to the Michigan State Medical Society.

Counties to Recommend DO's for Invitations to Centennial Session

Selected doctors of osteopathy will be invited for the first time to attend the annual scientific meeting in September of the Michigan State Medical Society.

The 55 component county medical societies of MSMS received a letter inviting them "to provide approved listings of osteopaths in their areas who could be invited to the Centennial Session in Detroit, September 19-24."

The Council at a recent meeting approved a recommendation of the MSMS Committee on Medicine and Osteopathy "that osteopaths on an individual basis be invited to attend the scientific program."

Guidelines in selecting the osteopaths were developed by the 1963 MSMS House of Delegates as those who "practice on the same scientific and ethical principles as doctors of medicine." The delegates further voted that "It shall not be considered unethical for members of MSMS to associate professionally and on a voluntary basis with doctors of osteopathy who base their practice on the same scientific and ethical principles as doctors of medicine."

They're Block Prints

The series of MICHIGAN MEDICINE covers about the special days of the Centennial have attracted considerable attention of MSMS members.

The art work has been done by Fred Ashby, who received his Bachelor of Fine Arts from the School of the Art Institute of Chicago.

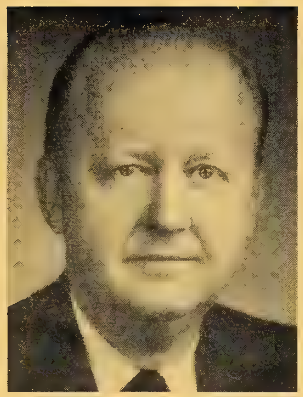
Working mostly as an industrial illustrator, he joined Sequoia Press in Kalamazoo in 1959.

Developing an interest in printmaking, he settled on linoleum cuts as a fast, yet distinctive technique and has turned out hundreds on subjects ranging from same size letterhead illustrations to landscapes and complete alphabets. The MICHIGAN MEDICINE linoleum cuts about the Centennial began in January.

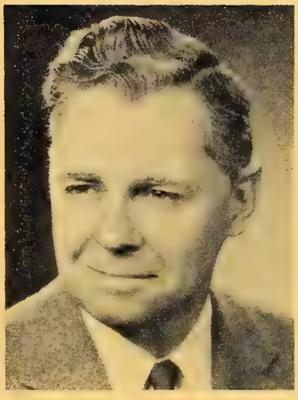
Did You Know?

"Michigan Medicine" received requests for 159,300 reprints during 1964. Requests for reprints were received for virtually every scientific article, with some of the requests running as high as 75,000.

Governor Romney



C. J. Stetler



Jenkin Lloyd Jones

INTRODUCING SOME MORE OF THE OUTSTANDING SPEAKERS FOR MSMS CENTENNIAL SESSION

AWARDS LUNCHEON, MONDAY, SEPTEMBER 20

C. J. STETLER, Executive Vice-President and General Counsel for the Pharmaceutical Manufacturers Association, will come from Washington, D. C., to address the luncheon Monday on "Medicine and Business, Industry and Communications Day." Until several years ago, Mr. Stetler was general counsel with the AMA. The MSMS House of Delegates at its Monday morning session and luncheon will present awards to 24 Michigan firms for their contributions to medicine and health. House of Delegates reference committees will meet in the afternoon and present reports to the evening session of the House.

CENTURY LUNCHEON, TUESDAY, SEPTEMBER 21

WYNDHAM DAVIES, M.D., M.P., a member of the House of Commons, will fly from England to address the Century Luncheon at Cobo Hall on Tuesday. The luncheon will include members of the House of Delegates, 50-Year-Club Awardees and others honored by the House, and all other interested physicians. The luncheon will immediately follow the official opening of the Centennial Session Exhibits. Doctor Davies has been highly recommended by the AMA as one of the leading spokesmen for the medical profession in England. The scientific program will be in operation Tuesday afternoon, overlapping the final day of the House of Delegates.

CULTURAL CENTER BANQUET, THURSDAY, SEPTEMBER 23

JENKIN LLOYD JONES, editor and publisher of the *Tulsa Tribune* and author of a nationally-syndicated column, will speak at the banquet Thursday when MSMS will observe "Medicine and Voluntary Health Day." A world traveler—twice around the world—he also has written a book, "The Changing World." A provocative writer and speaker, Mr. Jones will address MSMS members and friends at the Rackham Memorial Building in the Detroit Cultural Center. The dinner will be sponsored by Parke Davis and Company, and will follow a reception sponsored by the Wayne State University Alumni. A block of tickets is being reserved until September 1 at the Fisher Theater for those interested in seeing a play after the dinner.

GOVERNOR'S LUNCHEON, FRIDAY, SEPTEMBER 24

GOVERNOR GEORGE B. ROMNEY will speak at the luncheon Friday on "Medicine and Government Day." In addition to an address, Governor Romney will present special awards and recognition to Michigan physicians who are prominent in public service in their home communities or on the state level. The Friday morning program will deal with preventive medicine, and the afternoon seminar, open to the public and physicians, will consider "Medicine's Role in Government and Government's Role in Medicine." Speakers at the seminar will include such men as Rep. Durward G. Hall, Congressman from Missouri, and Samuel R. Sherman, M. D., Past President of the California Medical Association.

New Workmen's Compensation Law to Affect Many Physicians

The new Michigan Workmen's Compensation Law, effective September 1, 1965, will have an effect on many physicians.

The ramifications of the new law are pointed out by John P. Miron, assistant director of the State Workmen's Compensation Department.

"The new law requires that all private employers must carry workmen's compensation insurance if they regularly employ less than three employees, if at least one of the employees has been regularly employed for 35 or more hours per week for a period of 13 weeks or longer during the preceding 52 weeks," explains Mr. Miron.

"We know that many doctors do carry workmen's compensation insurance but others now will want to make such arrangements. This type of insurance can be obtained from the doctor's insurance agent. The insurance company covering them for workmen's compensation purposes will advise what forms are to be completed and filed in the event an injury does occur to one of their employees," he continues.

Medical Writers Plan National Meet in Detroit

"Michigan's Place in Medical History" will be one of the subjects for the Annual Convention of the American Medical Writers' Association, in Detroit, September 16-19—just preceding the MSMS Centennial Session.

The session with historic flavor will be held Saturday morning, September 18, according to C. Howard Ross, M.S., Ann Arbor, who is serving as national convention program chairman. Doctor Ross reports that all Michigan physicians and their wives are invited to attend.

The medical writers will confer at the Statler-Hilton Hotel to explore the theme, "Art and Science of Medical Expression — High Water Marks."

The convention will begin Thursday night, September 16, with a general session on "Planning and Scope" and then continue Friday morning with an "English Language Institute" and "Craft Clinics." Several deans and professors will speak during the afternoon on "Materials of Medical Expression" followed again by "Craft Clinics." The gala social evening will be Friday.

On Saturday, buses will take the writers after the President's Luncheon for a tour of Greenfield Village and the Henry Ford Museum with dinner at the Dearborn Inn. "Workshops in Writing and Editing" are scheduled for Sunday morning with help available from some of the outstanding national medical editors.

MSMS has invited the writers to participate in the special Sunday afternoon "Medicine and Religion Convocation" and to stay for the MSMS Centennial.

EXPLAIN VIEWS TO LEGISLATORS

A practice started several years ago has been continued this year to increase understanding between physicians and legislators.

Leaders of the county medical societies come to the MSMS headquarters building and confer for dinner with the state representatives and senators from their districts. The program usually is brief with informal comments by both the legislators and the physicians. Often the physicians then go down to the State Capitol to watch the legislators in session.

During the past legislative session, such meetings were held with physicians and legislators from the following counties — Gratiot, Isabella, Clare, Wexford, Missaukee, Berrien, Macomb, Oakland, Muskegon, Genesee and Wayne.

Doctors' Day Luncheon, New Auxiliary Event

A "Doctors' Day Luncheon" will be a new feature of the annual convention of the Woman's Auxiliary to MSMS in Detroit, September 21-22. The wives will be urged to bring their husbands to the "Doctors' Day Luncheon," Wednesday, September 22, to hear Leroy Augenstein, Ph.D., Michigan State University professor, who will discuss the population explosion.

The Auxiliary women will confer Tuesday morning through Wednesday afternoon and join their husbands for the MSMS Centennial Banquet at Cobo Hall that evening.

The Auxiliary convention will be held at the new Ponchartrain Hotel. The Tuesday luncheon will offer a fashion show, with fashions by Dinon Shop of Grosse Pointe.

During the convention, the gavel will be passed by Mrs. Milton R. Weed, Grosse Pointe Park, current president, to Mrs. Henry Scovill, Ypsilanti, the new president for 1965-66.

YPSILANTI — Cleary College presented honorary doctor of science degrees at its 1965 commencement to O. Ray Yoder, M.D., and James J. Woods, M.D., both of Ypsilanti. The commencement address to 181 students was given by Doctor Yoder.

Invite Entries for "Doctors Collect Art Show" in Detroit

The initial response has been encouraging to the invitation of the Detroit Institute of Arts for the special "Doctors Collect Art" exhibit during the MSMS Centennial Session.

The Institute points out that time is short for doctors to indicate their willingness to participate.

Doctors are asked to write Mr. Willis Woods, director, Detroit Institute of Arts, 5200 Woodward Avenue, Detroit 2, Michigan.

Ask Physicians Help Outfit Fort Hospital

Michigan physicians are invited to help the Mackinac Island State Park Commission restore the Fort Mackinac Post Hospital — where William Beaumont, M.D., treated Alexis St. Martin in 1822.

There is need for furnishings that may have been used in hospitals, particularly army hospitals, in the late 19th century, such as beds, tables, chairs, cabinets, etc. Also needed are medical instruments.

Persons having such materials that they may wish to donate should address their offers to: Eugene T. Petersen, Director of Historic Projects, Mackinac Island State Park Commission, Box 523, Mackinac Island, Michigan.

Michigan Foundation Gives 2 Scholarships

The Michigan Foundation for Medical and Health Education granted educational scholarships to two Michigan physicians to the recent Rutgers Summer School for Alcohol Studies.

The scholarships, $300 each, were awarded to John C. Morris, M.D., from Detroit, and Louis Bendezu, M.D., from Ypsilanti.

This is the second year that the Foundation has cooperated with the Michigan State Board of Alcoholism in making grants to practicing physicians. President of the Foundation is Earl I. Carr, M.D., Lansing.

AMA Honors Michigan Son

The newly-elected president elect of the AMA—Charles L. Hudson, M.D., of Ohio is a native of Merrill, Michigan, and a graduate of Alma College and the University of Michigan School of Medicine.

Professor at the Western Reserve University School of Medicine, Doctor Hudson presented the first Yates Lecture in Michigan in 1959 under the sponsorship of the Michigan Tuberculosis and Respiratory Disease Association. In that address to Michigan newsmen and physicians, he concluded with these remarks:

"At the risk of oversimplification, I believe I can summarize a plan for science writers and doctors in three brief statements:

"1. Meet to discuss coverage of medical scientific news, listen, talk, find out how much you really know, and make a plan to proceed.

"2. When divergent interests threaten to drive you apart, find at least one common objective.

"3. Do not misinterpret the intensions or otherwise discredit the views held by the other party but require that suspect statements be evaluated in relation to the common objective."

(A report from the MSMS delegates to the AMA Convention will appear in the September issue of Michigan Medicine.)

MSMAS Appeal To All Doctors:

Dear Doctors:

We sincerely hope that all physicians will encourage their medical assistants to participate in the 1965 Convention of the Michigan State Medical Assistants Society, September 22-23.

The Statler-Hilton Hotel, Detroit, will be the headquarters, with registration beginning Tuesday evening, September 21. The MSMAS House of Delegates will meet Wednesday morning. The luncheon will honor MSMAS past presidents, present county president, medical-assistants-of-the-year from each county and the Certified Medical Assistants. Fran Harris, WWJ-TV special features coordinator, will speak.

On Wednesday evening, the Medical Assistants will join the MSMS at the Centennial Banquet at Cobo Hall.

Thursday morning will feature a workshop type of meeting, when the girls will be able to ask a panel of experts questions about on-the-job problems. The luncheon will climax the MSMAS program.

—Michigan State
Medical Assistants
Society

Are Paintings Ready to Show?

Did you exhibit some art work last year in the Auxiliary show at the Annual Session? If so, the Auxiliary Committee sincerely hopes you will exhibit again at the Centennial Session show.

Do you have a painting, drawing, design, some sculpture, or ceramics that could be part of the show? If so, the Auxiliary Committee cordially urges you to help make the 1965 show the biggest and best.

"The Michigan Doctor and Wife Art Exhibit" will be held September 21, 22 and 23 at Cobo Hall.

"Advance registration by September 10, would be very helpful to the committee in planning for adequate display space. Those who fail to register in advance may do so at the beginning of the show," reports Mrs. George E. McKeever, Chairman.

If you have not already received an advanced registration form and would like to enter your original art work in the fall exhibit, please write to Mrs. George E. McKeever, 1767 Culver, Dearborn, 48124.

HOTEL RESERVATION FORMS TO CLIP AND MAIL TODAY FOR CENTENNIAL SESSION

SHERATON-CADILLAC HOTEL

Overall Centennial
Sept. 19-24

* * *

House of Delegates
Sept. 19-20-21

* * *

Scientific Programs
Sept. 21-22-23-24

Sheraton-Cadillac Hotel
MSMS Centennial Session Headquarters
Detroit, Michigan 48231

Please reserve the following room for me. I have circled the type of room and rate desired.

Single	Double	Twin
$ 9.00-$10.50-$11.75	$15.00-$16.25	$15.50-$18.50
$13.50-$15.50	$18.00-$20.00	$20.50-$22.00
$17.00-$18.50-$20.50	$21.50-$25.00	$23.50-$25.00

Suite (1 bedroom) $30.00-36.00-39.00-41.00

Name ____________________

Address ____________ City ____________ State ________

Arrival Date, a.m. or p.m. ________ Departure Date ________

Hotel Pontchartrain
MSMS Auxiliary Convention Headquarters
Two Washington Boulevard
Detroit, Michigan 48226

Please reserve the following room for me. I have circled the type of room and rate desired.

Single	Double	Twin
$12.50-$14.50-$15.00-$16.50	$17.50-$20.00	$20.50-$23.00
$17.00-$18.50-$19.00-$20.00	$23.50-$24.00	$26.00-$28.00
$22.00-$24.00	$25.00-$27.00	$30.00

Parlor & Bedroom—$45.00-50.00-60.00-75.00

Name ____________________

Address ________ City ________ State ________ Zip Code ______

Arrival Date ________ Time ________ Departure Date ________

Auxiliary Convention
Sept. 21-22

* * *

MSMS Centennial
Sept. 19-24

MSMS officers and the Centennial committees urge every MSMS member to decide today to participate in the Centennial Session in Detroit, September 19-24. Every member is urged to attend at least one day — to join in the special Centennial events and to take advantage of the postgraduate scientific program.

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Detroit, Michigan, September 19-24, 1965. The provisions of the Constitution and ByLaws and the Official Program will govern the deliberations.

Oliver B. McGillicuddy, M.D.
President

Harold H. Hiscock, M.D.
Council Chairman

J. J. Lightbody, M.D.
Speaker

Louis F. Hayes, M.D.
Vice Speaker

Attest:
D. Bruce Wiley, M.D., *Secretary*

OUR STATE SOCIETY

Official Call for 100th Annual Session Of Michigan State Medical Society

The 1965 House of Delegates of the Michigan State Medical Society will hold a three-day session beginning Sunday, September 19, with a special Centennial Convocation panel dealing with Medicine and Religion at 3:00 p.m. in Detroit's Ford Auditorium. The first business session of the House of Delegates will be conducted in the Grand Ballroom of the Sheraton-Cadillac Hotel, Detroit, commencing at 8:00 p.m.

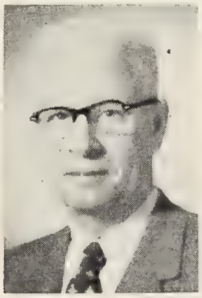
The House will also meet on Monday, September 20, at 8:30 a.m. and at 8:00 p.m. and on Tuesday, September 21, at 8:30 a.m. and at 8:00 p.m. The Tuesday morning meeting will be held in Cobo Hall, followed by the Century Luncheon and the Michigan Medical Service Annual Meeting in that location, with the House returning to the Sheraton-Cadillac Grand Ballroom for its Tuesday evening session.

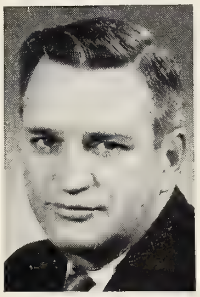
SEATING OF DELEGATES

"A Delegate, or in his absence, an Alternate Delegate (in order of seniority) becomes a member of the House of Delegates when duly registered and seated at the Annual Session following his election and certification by the component County Society. Once seated a Delegate shall remain a Delegate throughout the entire Session and thereafter until the next Annual Session of the House of Delegates and his place shall not be taken by any other Delegate or Alternate Delegate except that in case of emergency the House of Delegates may seat, for the duration of the emergency, a duly accredited Alternate Delegate from the same component County Society. Any Delegate-elect not present to be seated at the hour of call of the first meeting may be replaced by the accredited Alternate Delegate next on the certified list furnished by his component County Society."—MSMS Bylaws, Chapter 9, Section 4.

O. B. McGillicuddy, M.D.
Lansing
President

J. J. Lightbody, M.D.
Detroit
Speaker


H. H. Hiscock, M.D.
Flint
Council Chairman


L. F. Hayes, M.D.
Gaylord
Vice Speaker

D. B. Wiley, M.D.
Utica
Secretary

LOMOTIL *Pharmacologic Activity*

The significant pharmacologic actions of Lomotil are summarized as follows:

Evidence indicates that Lomotil acts directly on the intestinal musculature to inhibit excess peristalsis.

Lomotil is not known to inhibit nonpropulsive intestinal movements.

Roentgenograms demonstrate that this activity occurs within two hours after oral administration and persists for at least six hours.

Comparative studies in the rat show Lomotil to be more effective in inhibiting fecal excretion than either codeine or morphine.

Analgesic, anticholinergic, mydriatic and gastric secretory effects have not been significant.

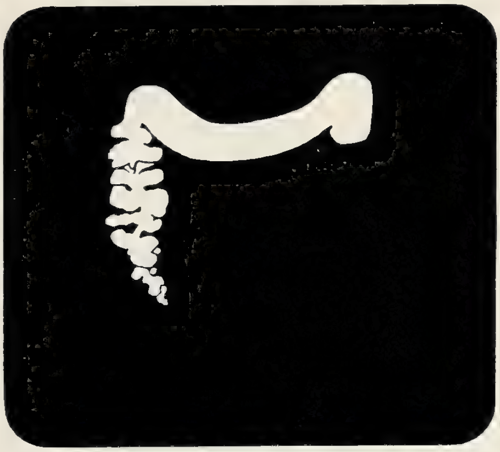
Reduction of propulsive motility with Lomotil relieves spasm and cramping, allows physiologic absorption of fluid and reduces frequency of evacuations to provide prompt, symptomatic control of virtually all diarrheas.

LOMOTIL®

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . 0.025 mg.

tablets • liquid

slows propulsion



relieves distress

stops diarrhea

Precautions: Lomotil is an exempt narcotic preparation of very low addictive potential: more than three million prescriptions have now been written for Lomotil. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, *given in divided doses,* until diarrhea is controlled, are:

Children:

3 to 6 months—3 mg. (½ tsp.* t.i.d.)
6 to 12 months—4 mg. (½ tsp. q.i.d.)
1 to 2 years—5 mg. (½ tsp. 5 times daily)
2 to 5 years—6 mg. (1 tsp. t.i.d.)
5 to 8 years—8 mg. (1 tsp. q.i.d.)
8 to 12 years—10 mg. (1 tsp. 5 times daily)

Adults:

20 mg. (2 tsp. 5 times daily or
2 tablets 4 times daily)

**Based on 4 cc. per teaspoonful.*

Maintenance dosage may be as low as one fourth the therapeutic dose.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE *Research in the Service of Medicine*

Order of Business:
1965 MSMS HOUSE OF DELEGATES

SUNDAY, SEPTEMBER 19, 1965

3:00 p.m.—FIRST MEETING—Ford Auditorium
Centennial Convocation—Medicine and Religion

6:00 p.m.—REGISTRATION—Grand Ballroom, Sheraton-Cadillac Hotel
Speaker's Dinner—Washington Room (briefing for Reference Committee Chairmen)

8:00 p.m.—SECOND MEETING—Grand Ballroom, Sheraton-Cadillac Hotel

1. Call to Order by Speaker
2. Report of Committee on Credentials
3. Appointment of Reference Committees
4. Remarks of the Speaker of the House—J. J. Lightbody, M.D., Detroit
5. SPEAKER OF THE EVENING—Walter H. Judd, M.D., Former Congressman, Minnesota
6. Report of the House of Delegates Committee on Certificates of Commendation
7. Report of the House of Delegates Committee on Michigan's Outstanding Physician
8. Report of the Judicial Commission
9. Introduction of Resolutions
10. New Business

MONDAY, SEPTEMBER 20, 1965

8:30 a.m.—THIRD MEETING—Grand Ballroom, Sheraton-Cadillac Hotel

11. Supplementary Report of Committee on Credentials
12. Introduction of Resolutions
13. President's Address—Oliver B. McGillicuddy, M.D., Lansing
14. President-Elect's Address—Luther R. Leader, M.D., Birmingham
15. Greetings of the Woman's Auxiliary—Mrs. Milton R. Weed, Detroit, President
16. Greetings of the Michigan State Medical Assistants Society — Miss Phyllis Marquardt, Kalamazoo, President
17. Annual and Supplemental Reports of The Council—Harold H. Hiscock, M.D., Flint, Chairman
18. Report of Delegates to the American Medical Association—William A. Hyland, M.D., Grand Rapids, Chairman
19. Report of Michigan Medical Service—Sidney Adler, M.D., Detroit, President
20. Reports of Committees of the House of Delegates
21. Reports of MSMS Standing and Special Committees
22. Presentation of Symbolic Awards to Michigan Business, Industry and Communications

12:30 p.m.—Business-Industry-Communications Awards Luncheon—Crystal Ballroom, Sheraton-Cadillac Hotel
Speaker—C. Joseph Stetler, General Counsel, American Pharmaceutical Manufacturers Association

8:00 p.m.—FOURTH MEETING—Grand Ballroom, Sheraton-Cadillac Hotel

23. Supplemental Report of Committee on Credentials
24. HONORS CEREMONY—PAST SPEAKERS OF THE MSMS HOUSE OF DELEGATES
25. SPEAKER OF THE EVENING—Percy E. Hopkins, M.D., Chairman of the Board of Trustees, AMA
26. Unfinished business
27. Introduction of Resolutions; Other New Business
28. Reports of Reference Committees

TUESDAY, SEPTEMBER 21, 1965

8:30 a.m.—FIFTH MEETING—Ballroom B, Cobo Hall

29. Supplemental Report of Committee on Credentials
30. Reports and Supplemental Reports of Reference Committees
31. Unfinished Business
32. Introduction of Resolutions; Other New Business
33. AWARDS:
    - Awards to Employees (per 1961 House of Delegates)
    - Fifty Year Awards
    - Certificates of Commendation
    - Michigan's Outstanding Physician

12:30 p.m.—Century Luncheon and Reception
Ballroom A, Cobo Hall, sponsored by Michigan Medical Service
Speaker: Wyndham R. Davies, M.D.
Member of Parliament
Poole, Dorset, Great Britain

8:30 p.m.—SIXTH MEETING—Grand Ballroom, Sheraton-Cadillac Hotel

34. Supplemental Report of Committee on Credentials
35. CEREMONY HONORING MSMS COMPONENT MEDICAL SOCIETIES
36. SPEAKER OF THE EVENING—Officer of the Canadian Medical Association
37. Unfinished Business
38. Supplemental Reports of Reference Committees
39. Induction of Incoming President of MSMS, Luther R. Leader, M.D., Birmingham

FORM FOR RESOLUTIONS TO HOUSE OF DELEGATES

Each resolution introduced in the House of Delegates shall be introduced by a Delegate. It shall be in writing and presented in triplicate to the Secretary. It shall be referred by the Speaker to the proper Reference Committee before action is taken thereon. (By-laws, Chapter 9, Section 13.)

Official printed resolution forms follow the below format:

Date________________

Introduced by:____________________, M.D.

________________County Medical Society

SUBJECT:____________________

Whereas, ____________________, and

Whereas, ________________, therefore be it

RESOLVED: ____________________

NOTE: Each Delegate is invited to send a copy of all resolutions to Speaker J. J. Lightbody, M.D., Box 152, East Lansing.

40. ELECTIONS:
 (a) Councilors:
  1st District—Wyman C. C. Cole, Sr., M.D., Detroit—Incumbent
  1st District—Ralph R. Cooper, M.D., Grosse Pointe—Incumbent (to fill unexpired term ending 1967)
  7th District—John J. Coury, M.D., Port Huron—Incumbent
  8th District—A. Carl Stander, M.D., Saginaw—Incumbent
  10th District—Edward H. Rodda, M.D., Bay City—Incumbent
  12th District—James R. Dehlin, M.D., Gladstone—Incumbent
  15th District—Robert J. Mason, M.D., Birmingham—Incumbent
 (b) Delegates to the American Medical Association:
  J. R. Heidenreich, M.D., Daggett—Incumbent
  W. A. Hyland, M.D., Grand Rapids—Incumbent
  O. J. Johnson, M.D., Bay City—Incumbent
  L. R. Leader, M.D., Birmingham—Incumbent
 (c) Alternate Delegates to the American Medical Association:
  Wyman C. C. Cole, Sr., M.D., Detroit—Incumbent
  G. B. Saltonstall, M.D., Charlevoix—Incumbent
  B. M. Harris, M.D., Ypsilanti—Incumbent
  Otto K. Engelke, M.D., Ann Arbor—Incumbent
 (d) President-Elect
 (e) Speaker of the House of Delegates
 (f) Vice Speaker of the House of Delegates
41. Introduction of the new MSMS President-Elect
42. Adjournment.

SCHEDULE OF THE GENERAL MEETING OF THE MICHIGAN STATE MEDICAL SOCIETY

Formal installation of the President of the Michigan State Medical Society will take place during a general meeting of the Society at the time of the Centennial Banquet:

Wednesday, September 22, 1965, in the Ballroom, Cobo Hall, Detroit.

Special decorations will be furnished by the MSMS Woman's Auxiliary and special entertainment is arranged.

Presiding: Oliver B. McGillicuddy, M.D., Lansing, President.

Installation of New President: Luther R. Leader, M.D., Birmingham.

MICHIGAN MEDICAL SERVICE SCHEDULE
Tuesday, September 21, 1965

2:00 p.m. Meeting of Members of the Corporation
Ballroom B, Cobo Hall

All MSMS Delegates are members of Michigan Medical Service Corporation and are expected to attend both the Century Luncheon and the MMS Annual Meeting. The Annual Meeting is open to ALL members of the medical profession, who are cordially invited to attend.

★

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CULTURAL TOURS, EXHIBITS SLATED DURING CENTENNIAL

Participants at the Centennial Session in Detroit will be keenly interested in the special exhibits planned by the cultural institutions in Detroit. Further involvement will be in the form of conducted tours for physicians, their wives, and other guests during Thursday, September 23.

This colorful aspect of the Centennial Session is being coordinated by the Detroit Adventure organization, with Hamilton Stillwell, as director.

During the Centennial, the Detroit Institute of Arts will present a special show, "The Doctor Collects Art."

The Detroit Historical Museum will develop a special exhibit in its main lobby to commemorate 100 years of medical service.

The Detroit Public Library is developing one or more special exhibits that will be of interest to MSMS members especially.

Other institutions will share in the conducted tours on Thursday—"Medicine and Voluntary Health Day." On that day, charter buses will leave from the Cobo Hall area in the afternoon and take doctors, their wives, voluntary health leaders, and others to the Detroit Cultural Center on Woodward. The participants will select the institution of their choice and follow guides for a first-hand tour. Doctor Stillwell reports the following institutions

Special plans of the Detroit cultural institutions in the MSMS Centennial are being coordinated by Hamilton Stillwell, at the head of the table to the left, director of the Detroit Adventure project. Plans recently were advanced for the colorful shows and conducted tours at a luncheon meeting at Rackham Building by the following: left to right, beginning with Doctor Stillwell; Joyce Malcolm, Detroit Artists Market; Virginia Brose, Detroit Institute of Arts; Richard Campau, MSMS; Harry Veeder, Detroit Historical Museum; Herbert Auer, MSMS; Alacaque D. Barrow, Detroit Adventure; Sarkis Surkisian, Arts and Crafts Art School; and Jewell Mansfield, Detroit Public Library.

Say you saw it in Michigan Medicine

are cooperating—Detroit Public Library, Detroit Historical Museum, Detroit Institute of Arts, Detroit Arts and Crafts Art School, and Wayne State University.

All the special shows will be open to the public during the Centennial week, and thousands of Detroit area residents will see exhibits which relate to Michigan medicine.

Enrollment Up At Spring PG Series

The Spring series of MSMS postgraduate lectures—and especially the clinical conferences in the afternoons—was well received by MSMS members. Attendance at 21 programs this spring was up 8 per cent higher than last spring, according to Harry A. Towsley, M.D., Ann Arbor, Committee chairman.

Following are some additional comments by Doctor Towsley about the spring program:

"Inasmuch as the annual Michigan Clinical Institute was discontinued, the Committee decided to attempt to expand its postgraduate activities in certain centers by providing half-day clinical sessions and evening discussions to compensate for the omission of the Clinical Institute. These expanded clinical conferences were held in the spring of 1965 at Port Huron, Marquette, Kalamazoo, and Midland. There is unanimous agreement in reports from the centers and from the participating faculty that these programs were highly successful.

"A small measure of success in the spring 1965 program is indicated by comparing the attendance figures with those for the spring of 1964. Of the total membership 47.4 per cent of these component county societies where programs were provided in the spring of 1965 took advantage of the continuing educational opportunities available to them, compared to 39.5 per cent in the spring of 1964.

"This Spring, 41 faculty members representing the two medical schools in Michigan took on this added responsibility for the continuing education of physicians throughout the state. Of this number, one was a dean, 12 were professors and chairmen of departments, nine were professors, nine were associate professors, four were assistant professors and six were instructors.

"The Michigan State University has been added as a co-sponsor of MSMS postgraduate extramural programs, and Andrew D. Hunt, M.D., Dean of the College of Human Medicine, was appointed an advisor to the Committee.

"The Committee is especially grateful to the physicians who have participated in the teaching program. The joint effort of the Medical Schools of the state to provide teachers for this program throughout the state has been an outstanding record of cooperation and achievement."

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MSMS Centennial Session Exhibitors:

MSMS is proud to present the finest scientific and commercial exhibit in its history at its Centennial Session in Detroit.

The exhibition will be in Cobo Hall in conjunction with the scientific meetings beginning Tuesday noon, September 21.

All physicians are urged to visit the educational displays, to take advantage of the new information available and also to express appreciation for the exhibitors' contribution to the MSMS Centennial postgraduate program.

The following commercial exhibitors will present special displays for physicians:

Abbot Laboratories
Aloe Medical
Americana Corporation
American Massage of Taylor
Ames Company, Inc.
Astra Pharmaceutical Products, Inc.
Ayerst Laboratories

Barnes-Hind Laboratories
Belle Moss Pharmaceutical Chemist
Berkeley Medical Instruments
Beutlich, Inc.
Borcherdt Company
The Borden Company
Bristol Laboratories
Burroughs Wellcome & Company

Carnation Company
Ciba Pharmaceutical Products, Inc.
Coca-Cola Company
Control-O-Fax Sales
Cottrell-Clarke, Inc.
Cunningham Drug Stores, Inc.
Cutter Laboratories

Davis-Smith Agency
Detroit X-Ray Sales Company
Dictaphone Corporation
Dome Chemical, Inc.
Doyle Pharmaceutical Company
Dy-Dee Wash, Inc.

Eaton Laboratories, Inc.
Encyclopaedia Britannica

Ferndale Laboratories, Inc.
Flint Laboratories, Inc.
Fuller Pharmaceutical Company

Geigy Pharmaceuticals
Gerber Products Company
Great Books of the Western World

Hack Shoe Company
Hankscraft Company

G. A. Ingram Company
Insurance by North America

The Jobst Institute, Inc.
Johnson & Johnson

Key Pharmaceuticals
Knoll Pharmaceutical Company
A. Kuhlman & Company

Lederle Laboratories
Leonard's Shoes, Inc.
Eli Lilly & Company
J. B. Lippincott Company
Lloyd Brothers, Inc.
Loma Linda Food Company
P. Lorillard Company
C. DeWitt Lukens Company

Maico Hearing Service
Marion Laboratories, Inc.
Marshall Erdman & Associates, Inc.
McNeil Laboratories, Inc.
Mead Johnson Laboratories
Medac by Bank of the Commonwealth
Medco Products Company
Medical Arts Supply Company
Medical Protective Company
Merck Sharp & Dohme
Meyer Laboratories
Michigan Association of Collection Agencies
Michigan Bell Telephone Company
Michigan Medical Service
MSMS Life, Health & Accident Insurance

National Drug Company
North American Pharmacal
Northern Air Service, Inc.

Organon, Inc.
Ortho Pharmaceutical Corporation

Pacific Medical Equipment Company

Parke, Davis & Company
Pet Milk Company
Photoeaze Manufacturing, Inc.
Physician's Counseling Service
Pitman-Moore Company
Procter & Gamble Company
Professional Management

Randolph Surgical Supply Company
R. J. Reynolds Tobacco Company
Riker Laboratories, Inc.
A. H. Robins Company, Inc.
Roche Laboratories
Wm. H. Rorer, Inc.
Ross Laboratories
C. J. Rouser Supply Company

Sanborn Company
Sandoz Pharmaceuticals
W. B. Saunders Company
Schering Corporation
Julius Schmid, Inc.
G. D. Searle & Company
Seven-Up Developers of Michigan
Sherman Laboratories
Siemens Medical of America, Inc.
Smith Kline & French Laboratories
Smith, Miller & Patch, Inc.
E. R. Squibb & Sons
Stenocord Corporation
Strasenburgh Laboratories
The Stuart Company
Syntex Laboratories, Inc.

United States Tobacco Company
The Upjohn Company

Vernor's, Inc.

Wallace Laboratories
Warren-Teed Products Company
Westwood Pharmaceuticals
White Laboratories
Winthrop Laboratories, Inc.
W-T-S Pharmaceuticals

X-Ray Identification Corporation

Be Sure to Visit Exhibits at Cobo Hall During Centennial Session

Abstract of MSMS Council Action

Meeting of June 16, 1965

PROPOSED MSMS PROGRAM FOR RESEARCH AND DEVELOPMENT

The Council requested the MSMS Committee on Medical Socio-Economics to study a proposal and report to The Council prior to September whether it wishes to expand the scope and function of the Medical Socio-Economic Committee to include long-range research and development or wishes to recommend that a new committee be created for this purpose.

DISTRICT CHAIRMEN FOR CENTENNIAL SESSION

The Council designated each Councilor and Officer as a "District Chairman" for the Centennial Session so that MSMS could use more local names in news releases.

MSMS REPRESENTATIVE TO THE HEALTH FACILITIES PLANNING COUNCIL

The Council named D. Bonta Hiscoe, M.D., Lansing, as MSMS representative to the Health Facilities Planning Council of the Hospital Research and Educational Reserve.

PROGRESS ON JUDICIAL COMMISSION STUDY COMMITTEE

The Council received a progress report from the Judicial Commission Study Committee which has completed its recommended Constitution and Bylaws changes to create an MSMS Judicial Commission. This report will be sent to Delegates and Officers of component medical societies more than 30 days in advance of the House of Delegates session.

PATIENT'S BILL OF RIGHTS FOR QUALITY MEDICAL CARE

The Council endorsed the following amended statement:

1. Each patient must have freedom of choice of physician and each physician must be free to offer his services to all patients.
2. The patient's physician must be free of controls and restrictions that interfere with providing the highest quality of medical care.
3. The freedoms we believe necessary for patients and physicians should apply to all aspects of medical care.
4. The quality of the patient's medical care must be judged by practicing physicians, and committees concerned be responsible only to their own hospital staffs or local medical associations.
5. The primacy of a physician's responsibility to his patient cannot be delegated or usurped by a hospital or other corporation.
6. Any plan for financing medical costs must recognize variables in cost of provision, and kinds of service; and must not interfere with the individual patient-physician contract.
7. The principle of reciprocal doctor-patient responsibility must be preserved.

REVIEW OF MSMS BUDGETARY METHODS AND ACCOUNTING PROCEDURES

Upon recommendation of the Finance Committee, The Council approved the first phase of a proposed review of existing budgetary methods and accounting procedures, in the belief that such a review would improve the MSMS operation. The study will be done by MSMS staff with the help of special consultants.

CENTENNIAL ISSUE OF MICHIGAN MEDICINE

The Publication Committee designated as the Special Centennial Session Issue the September number of MICHIGAN MEDICINE.

PUBLICATION OF MSMS HISTORY

Upon recommendation of the Publication Committee, The Council authorized the publication, in hard cover, of the MSMS history series written by MSMS Historian Wm. J. Stapleton, Jr., M.D., which has appeared in MICHIGAN MEDICINE, beginning in September, 1963. Copies of the hard-cover booklet will be available at a nominal cost at the Centennial meeting.

MATERNAL HEALTH

Upon recommendation of the Maternal Health Committee, The Council approved the Committee's proposed Michigan Perinatal Mortality Study and authorized the printing and distribution of Maternal Health Desk Reference Card No. 6, with the inclusion of a questionnaire regarding the use and value of the Maternal Health Desk Reference Cards. The Council also approved the sending of Desk Reference Cards Nos. 1-6, and future cards, to hospital administrators for posting in delivery rooms.

MSMS to Add 32 to 50-Year Club

One of the highlights of the 1965 House of Delegates meeting will be the presentation of the coveted "50-Year Pin" to 32 members of the Michigan State Medical Society.

These physicians will attend the Detroit meeting to receive the pins on Tuesday morning, September 21, before the applauding delegates. The pins will be mailed to the men who are not able to be present. Following the ceremony, the physicians will be honored guests at the Century Luncheon at Cobo Hall, one of the Centennial Session highlights.

Calhoun County
R. H. Fraser, M.D.
Clinton County
Charles T. Foo, M.D.
Crawford County
Stanley Stealy, M.D.
Genesee County
George J. Curry, M.D.
John J. Kurtz, M.D.
George D. Sutton, M.D.
Grand Traverse County
Russell R. Huston, M.D.
Ingham County
Bertha W. Ellis, M.D.
C. Ward Ellis, M.D.
O. M. Randall, M.D.
Jackson County
R. M. Cooley, M.D.
C. E. De May, M.D.
Frank Pray, M.D.
Menominee County
W. S. Jones, M.D.
Muskegon County
Marie Keilin, M.D.
Washtenaw County
A. C. Furstenberg, M.D.
Wayne County
Van D. Barnes, M.D.
Edward T. H. Best, M.D.
James G. Carr, M.D.
Harold E. Clark, M.D.
Thomas H. Crews, M.D.
J. J. Drake, M.D.
Robert Greenidge, M.D.
John W. Hansen, M.D.
Harry E. Lee, M.D.
Daniel J. Leithauser, M.D.
William W. MacGregor, M.D.
Elwood A. Sharp, M.D.
Max Silverman, M.D.
Fred M. Slaughter, M.D.
Hugh A. Sullivan, M.D.
Jacob M. Sutherland, M.D.

The list of 50-year awardees takes on added meaning this year as MSMS celebrates its 100 years of service to the residents of Michigan.

The records at the MSMS headquarters reveal that the following living doctors are among those in the coveted "50-Year Club." (Editor's Note: MSMS would appreciate any comments about corrections or additions.)

1964 Awardees
Herbert C. Allison, M.D.
Stilson R. Ashe, M.D.
L. Byron Ashley, M.D.
R. H. Baribeau, M.D.
Clarence D. Barrett, M.D.
Ladislaus Bogusz, M.D.
A. B. Bower, M.D.
Audrey O. Brown, M.D.
Dudley W. Byers, M.D.
George L. Caldwell, M.D.
Malcolm D. Campbell, M.D.
Aaron L. Chapman, M.D.
Clarence M. Clark, M.D.
Lyman W. Crossman, M.D.
Ira G. Downer, M.D.
Hazel Eidson, M.D.
Samuel J. Eder, M.D.
W. B. Fillinger, M.D.
Herbert E. Fogt, M.D.
David B. Hagerman, M.D.
R. John Hardstaff, M.D.
Arthur B. Henderson, M.D.
Leslie T. Henderson, M.D.
J. Stewart Hudson, M.D.
Bror H. Larsson, M.D.
Arlington F. Lecklider, M.D.
Harry Lewin, M.D.
S. L. Loupee, M.D.
Reginald D. McGeouch, M.D.
Frank A. Mercer, M.D.
John K. Ormond, M.D.
Orlando W. Pickard, M.D.
F. L. Pierce, M.D.
Harry C. Saltzstein, M.D.
Simon H. Sauter, M.D.
Arthur E. Schiller, M.D.
Milton Shaw, M.D.
Eugene Steinberger, M.D.
Albert M. Wehenkel, M.D.
David Weingarden, M.D.
Carl G. Wencke, M.D.
Gerald A. Wilson, M.D.

1963 Awardees
Leon M. Bogart, M.D.
Guy D. Briggs, M.D.
Clarence L. Candler, M.D.
Lowry C. M. Conley, M.D.
O. P. Geib, M.D.
Frank B. Gerls, M.D.
Howard Havers, M.D.
Raymond E. Hillmer, M.D.
William Huyser, M.D.
Charles S. Kennedy, M.D.
Isaac S. Lilly, M.D.
Gordon S. McAlpine, M.D.
William R. McClure, M.D.
Robert C. Moehlig, M.D.
Harold L. Morris, M.D.
Roy A. Morter, M.D.
Harold F. Ohrt, M.D.
Dorsey W. Patterson, M.D.
Maurice L. Richardson, M.D.
William D. Ryan, M.D.
Ernest C. Schultz, M.D.
F. Janney Smith, M.D.
Fred G. Swartz, M.D.
Grant Thorburn, M.D.
Charles S. Wilson, M.D.
William R. Young, M.D.

1962 Awardees
C. E. Boone, M.D.
Marion E. Bovee, M.D.
Julius Y. Burnstine, M.D.
George C. Burr, M.D.
William S. Chapin, M.D.
E. I. Carr, M.D.
Clair L. Douglas, M.D.
Clarence H. Eisman, M.D.
C. B. Fleischmann, M.D.
George A. Ford, M.D.
Ledru O. Geib, M.D.
Ellis R. Green, M.D.
Charles W. Husband, M.D.
Alfred LaBine, M.D.
Vilda S. Laurin, M.D.
Carey P. McCord, M.D.
Lyman J. Pinney, M.D.
Homer Ramsdell, M.D.
Paul C. Rohde, M.D.
Elmer W. Schnoor, M.D.
Clarence D. Selby, M.D.
George Sewell, M.D.

Willard R. Vaughan, M.D.
John N. Wenger, M.D.
J. C. Webster, M.D.
E. Kyle Simpson, M.D.

1961 Awardees

Joseph A. Bakst, M.D.
Wyman D. Barrett, M.D.
Glenn B. Carpenter, M.D.
Henry R. Carstens, M.D.
Howard H. Cummings, M.D.
Ernest W. Dales, M.D.
Harry F. Dibble, M.D.
George R. Goering, M.D.
Raymond S. Goux, M.D.
LeRoy W. Hull, M.D.
Buenaventura Jimenez, M.D.
H. Walter Reed, M.D.
Robert D. Scott, M.D.
Elisha S. Sevensma, M.D.
G. Howard Southwick, M.D.
Henry J. Vanden Berg, M.D.

1960 Awardees

Myra E. Babcock, M.D.
William N. Braley, M.D.
Harry J. Butler, M.D.
Nicholas Galdonyi, M.D.
Henri L. Gratton, M.D.
A. D. LaFerte, M.D.
William E. Miller, M.D.
Fred W. Organ, M.D.
Jean P. Pratt, M.D.
Stelios N. Sakorraphos, M.D.
Alvord R. Sanderson, M.D.
Arthur R. Smeck, M.D.
Rene J. St. Louis, M.D.
Elisha J. Tamblyn, M.D.

1959 Awardees

Corwin S. Clarke, M.D.
Henry Cook, M.D.
Ferdinand Cox, M.D.
Heman E. Grant, M.D.
E. V. Joinville, M.D.
John S. Lambie, M.D.
Perry C. Robertson, M.D.
John T. Sample, M.D.

1958 Awardees

Samuel Glassman, M.D.
L. W. Howe, M.D.
Mark Marshall, M.D.
Harriet E. McLane, M.D.
Paul Van Riper, M.D.

1957 Awardees

R. B. Clement, M.D.
B. R. Corbus, M.D.
F. J. Drolett, M.D.
Clarence Gillette, M.D.
G. J. Stuart, M.D.
S. W. Thieme, M.D.
C. A. Van Dusen, M.D.
John Ver Meulen, M.D.

1956 Awardees

E. G. Bellinger, M.D.
L. L. Harrison, M.D.
John W. Orr, M.D.
Frank J. Sladen, M.D.
Claude A. Smith, M.D.

1955 Awardees

Nathaniel Gates, M.D.
Alvin H. Seibert, M.D.
Aloysius J. Zaremba, M.D.

1954 Awardees

Wm. E. Blodgett, M.D.
Geo. H. Boyce, M.D.
Herman C. Emmert, M.D.

1953 Awardees

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John C. Dodds, M.D.

1952 Awardees

B. L. Franklin, M.D.
W. J. Jend, M.D.
G. P. Raynale, M.D.

1951 Awardees

G. C. Conkle, M.D.
J. W. Gethings, M.D.
Simon Levin, M.D.
E. D. Sage, M.D.

1950 Awardees

George R. Pray, M.D.
Wm. J. Stapleton, Jr., M.D.

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D. J. McColl, M.D.
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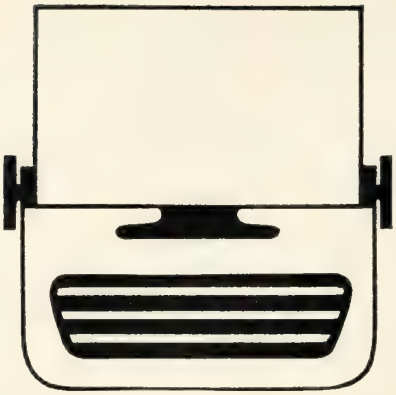


EDITORIAL VIEWS

ARE YOU COMING TO CENTENNIAL?

By C. Allen Payne, M.D.
General Chairman
MSMS Centennial Session

What day will I see you at the MSMS Centennial Session?

What day—or days—do you have marked now on your office appointment book? Will it be . . .

Sunday, September 19, "Medicine and Religion Day,"

Monday, September 20, "Medicine and Business, Industry and Communications Day,"

Tuesday, September 21, "Medicine and Medical Organization Day,"

Wednesday, September 22, "Medicine and Science Day,"

Thursday, September 23, "Medicine and Voluntary Health Day,"

Friday, September 24, "Medicine and Government Day."

While the delegates will confer Sunday, Monday and Tuesday, there also will be events those days of interest to all physicians. And this year the scientific program will begin on Tuesday noon, whereas in the past it always started on Wednesday. This year, the exhibits will be open Tuesday noon through Thursday, and the scientific program from Tuesday noon through Friday.

What day will I see you at the MSMS Centennial Session?

THE MEANING OF MERIT RATING

By Sidney Adler, M.D., President
Michigan Medical Service

Michigan Medical Service has adopted a merit rating system effective July 1, 1965. Its impact on the 3,500,000 Blue Shield subscribers and the physicians who serve them cannot be over-emphasized.

Theoretically, merit rating is the financial cushion to guarantee solvency to the voluntary prepayment health care system in Michigan.

Practically, merit rating is the start of a new era in health care which envisions wider scope of benefits and continued growth of quality medical care.

How does merit rating work and what does it mean to subscribers?

Merit rating spreads the cost of health care more equitably among Blue Cross-Blue Shield groups. Previously, one rate was established for all groups. This was known as "community rating." Under the new system, groups will be rated in relation to size and geographic location.

Groups will be separated by size—under and over 150 contracts. Rates for each group with 150 or more contracts will be influenced by the "experience" or frequency of use of benefits by group members. Good experience means lower rates; poor experience, higher rates.

But regardless of the group's poor experience, its rates cannot increase more than 20 per cent from year to year. This will prevent any group from being priced out of the health care market.

Groups with fewer than 150 contracts will retain their present Blue Shield community rate. They also will be community rated in five geographic areas by Blue Cross. This will generally result in lower Blue Cross-Blue Shield rates for the smaller groups.

There will be no change in rates for senior citizens, non-group subscribers or group conversion subscribers who have left their groups because of retirement or other reasons.

What does merit rating mean to physicians?

Merit rating means continued protection of low-income groups and senior citizens—the people we have subsidized in delivering a socially responsible service. These people will not be shut off from quality medical care.

Merit rating will spread more equitably the cost of health care for low-income groups. This will help Blue Cross-Blue Shield attract more groups and permit the extension of service and benefits to more people.

Merit rating will encourage utilization control because it affords lower rates to those groups with less frequent use of benefits.

Merit rating will eliminate general rate increases affecting Blue Shield's entire membership and thus attract less public attention and unjust criticism of the medical profession.

Hopefully, merit rating will create greater solvency for Blue Shield and the ability to revise the relative value fee schedule, where such revision is overdue.

And, perhaps most important, merit rating will make it economically possible for Blue Shield to expand the scope of benefits.

A long list of progressive medical care services negotiated by labor and the automobile industry are being examined by Blue Shield and the medical profession.

New and extended benefits awaiting implementation include.

- Extended nervous and mental benefits from 30 to 45 days, with the renewal period reduced from 180 days separation to 90 days.
- Psychiatric care services rendered in physicians' offices, night and day care centers and the outpatient group psychotherapeutic services, psychological testing, and electro-shock therapy and anesthesia.
- Extension of professional services in facilities other than acute general hospitals, with fees to physicians provided on a visit basis. Medical care in nursing homes and in rehabilitation institutions is presently offered within the framework of two pilot studies being conducted by Blue Shield.
- Elimination of the 270-day waiting period for obstetrical services.
- Dependent, unmarried children between 19 and 25 years of age and children of any age if totally and permanently disabled to be included under existing contracts.

These are a few of the progressive benefits confronting prepayment health care. Labor and management are looking to the medical profession for leadership in this area.

Merit rating offers Blue Shield and physicians an opportunity to expand their services and continue to provide the best medical care at the lowest possible price.

LITTERBUGS

By Harry R. Hall
Executive Vice President
Michigan State Chamber of Commerce

The affluence of our society has been both a blessing and a curse, as we have progressed to the highest pinnacle of financial success. With all of our wealth, we have become a nation of "slobs," in some respects.

Every hour of every day, the American citizen drops litter at the rate of 76 tons for every 60 seconds. That is more than a ton every second.

The current cost of litter clean-up in Michigan is estimated conservatively at about $750,000 a year. Much of this is spent in highway clean-up costs, with the remainder being spent by communities, industries and organizations in various clean-up activities.

Michigan's Anti-Litter Law

. . . Prohibits littering of all public and private property.

. . . Defines litter as "foreign substances of every kind and description."

. . . Establishes littering as a misdemeanor, permitting the judge to use discretion as to the penalty, but allowing a judge to sentence an offender to clean up sections along the highway.

The Michigan State Chamber of Commerce has taken the leadership in a "Keep Michigan Beautiful, Inc," public service organization, dedicated to the preservation and the improvement of Michigan's scenic beauty through the elimination of litter.

Keep Michigan Beautiful hopes to make Michigan the best-groomed state in the nation, and solicits the support of all government agencies, industries, individuals, and all who want to join in this worthwhile venture.

GENESEE SOCIETY GIVES FOR MUSEUM

A $50,000 donation toward establishment of a Genesee County health museum has been presented to the Flint College and Cultural Development by the Genesee County Medical Society.

The gift represents surplus funds from the medical society's mass oral polio vaccine program last November and January.

Accepting the donation at the medical society's monthly meeting at the Mott Children's Health Center was Donald E. Johnson, president of the College and Cultural Development. Mr. Johnson called the museum "a fine idea" and said he would recommend its construction to the development's Committee of Sponsors.

The health museum could be part of a museum complex in the College and Cultural Center, of which the Sloan Panorama of Transportation, now under construction, is the first unit, he said.

A museum would have educational exhibits and would be used by schools as well as the public.

Washtenaw Forums

A series of public medical forums will be sponsored in the Rackham building this fall by the Public Relations Committee of the Washtenaw County Medical Society.

Subjects under consideration include Cancer, Heart, High Blood Pressures and Strokes, Teen-Age and VD, Menopause, Health and Retirement, Religion and Medicine, and the Use and Abuse of Home Remedies.

COUNTY SOCIETIES

FETE SCHOLARS

Saginaw County Medical Society entertained top students from the graduating classes of Saginaw County high schools at a reception at St. Mary's Hospital student nurse residence. Here (left to right) Larry Doehring, son of Mr. and Mrs. Paul F. Doehring, Merrill, and Mary Otto, daughter of Mr. and Mrs. Karl F. Otto, Merrill, are greeted by Dr. and Mrs. Robert J. Toteff. Doctor Toteff was reception chairman. (Saginaw News Photo).

* * *

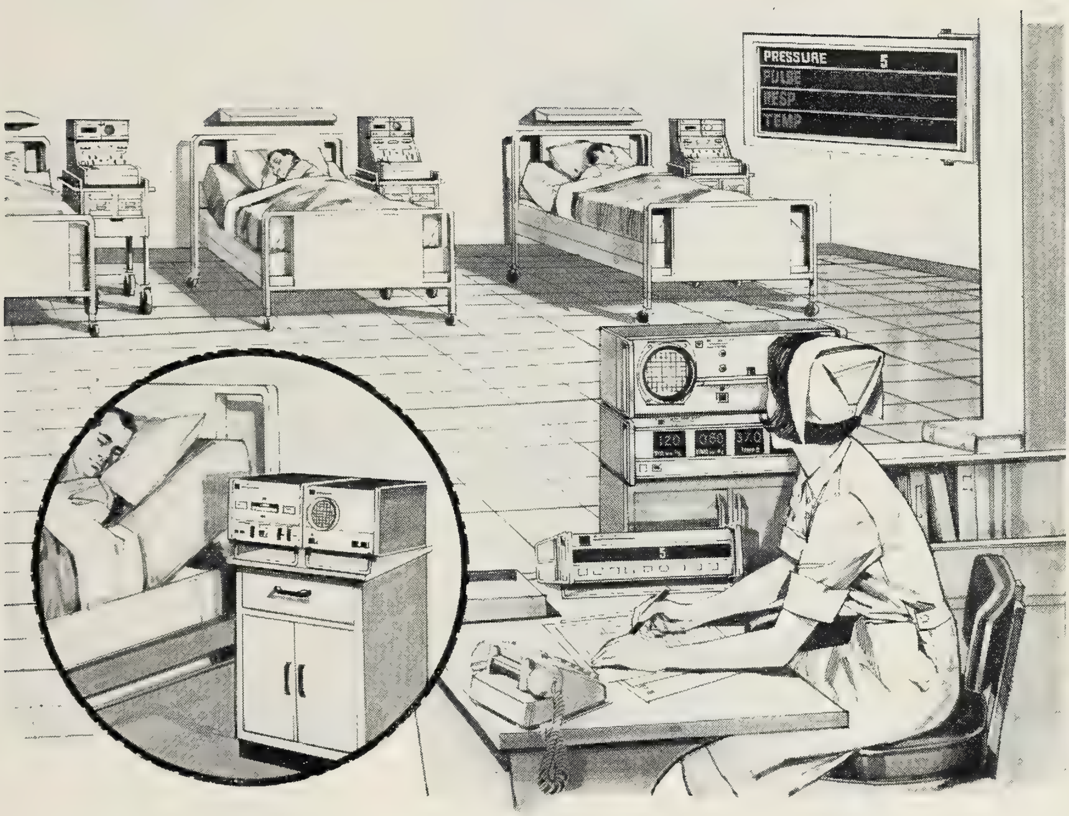
The annual Saginaw County Medical Society reception honoring the outstanding scholars of Saginaw County was the largest in the history of the project. About 250 people attended the reception, including 20 doctors and their wives as well as parents of the honor students and high school principals.

The top 5 per cent of all high school graduates in the county were invited. The idea of such an event originated with a group of doctors having a "bull session" at one of the hospitals in the doctors' lounge a few years ago, when someone commented that high school athletes receive all of the publicity and some recognition should be given those kids who were doing a fine job in the classroom. It has been an annual event ever since and an effective public service project for the Society.

AMA-NEA Statement Of Interest to Counties

Schools and communities are urged to take more responsibility in supplementing the home in teaching facts about sexual reproduction and the values of the family system in a recent statement of the Joint Committee on Health Problems in Education of the AMA and NEA.

Recognizing that preventive measures such as better sex instruction by parents and schools "will be slow in effecting results" with respect to the problem of early and unwanted pregnancies, the Committee re-emphasized its statement of 1963 urging schools and communities to "devise a plan for the continued education for married students and unwed parents."



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ANCILLARY SECTION

PLANNING COUNCIL WELL UNDERWAY

Seven major accomplishments are reported by the Michigan Health Facilities Planning Council, which includes MSMS membership.

D. Bonata Hiscoe, M.D., of Lansing, is a member of the Council, representing the Michigan State Medical Society. Another member is Vergil Slee, M.D., director, Commissioner on Professional and Hospital Activities, Ann Arbor.

Harry Parke, director, reports that in the few short months that the Hospital Research and Educational Reserve of Michigan has been in operation, the following have been undertaken:

1. The corporate membership has been recruited.
2. A 15-man board of directors has been elected.
3. A three-year financing program is nearing completion.
4. The membership of the Michigan Health Facilities Planning Council has been appointed.
5. A general statement of purpose and goals has been developed.
6. Council offices have been opened in Lansing.
7. A director and secretary have been employed and additional staff is being recruited.

In the research area of its responsibility, the Reserve is conducting with the Michigan Hospital Association and the Southwestern Hospital District an experimental program to achieve substantial savings in hospital costs through the massive application of modern management techniques and systems engineering. If this program is successful in the pilot area, the Reserve will make every effort to extend the program throughout the state. This $170,000 project is financed in part by a Kellogg grant of $97,000.

The Council also will function in the fields of planning, education and service.

The attention of the Council will be directed not only to bed needs and bed construction, but also to the development, provision, coordination and sharing of all health programs, services and facilities.

The prime objective is to make available to all of the citizens of Michigan the best possible quality care in modern facilities which are operated at maximum efficiency and economy.

New Leaders of National Organizations

The new president of the American Thoracic Society is Winthrop N. Davey, M.D., of Ann Arbor. Doctor Davey, University of Michigan professor of internal medicine and director of the medical unit for tuberculosis of the University Medical Center, was installed at the recent annual meeting in Chicago.

A national authority in the field of tuberculosis control and treatment, Doctor Davey presented a paper at the recent national meeting of the National Tuberculosis Association on the "Epidemiology of Tuberculosis and Other Respiratory Diseases."

William H. Beierwaltes, M.D., Ann Arbor, took office June 18 as president of the Society of Nuclear Medicine at the Society's annual meeting in Bal Harbour, Florida.

Doctor Beierwaltes is professor of internal medicine at the U-M Medical School, and director of the Clinical Nuclear Medicine unit at University Hospital.

The Society is an international organization of physicians, chemists, physicists, biologists, and other scientists.

Orthopaedic Meeting, Sept. 21

The Michigan Orthopaedic Society will hold its annual meeting at the Dearborn Inn on Tuesday evening, September 21, according to President Curtis M. Hanson, M.D., Kalamazoo.

The annual summer workshop was held at Hidden Valley, Gaylord, June 10, 11

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LIBRARY OPENS

Chris J. D. Zarafonetis, M.D., professor of medicine, watches Mrs. C. C. Sturgis cut the ribbon that officially opened the new Cyrus C. Sturgis Library of Hematology at the University of Michigan. The Library is housed in newly-furnished quarters at The Thomas Henry Simpson Memorial Institute for Medical Research of which Doctor Sturgis was director from its opening in 1927 until his retirement in 1956. A portrait of Doctor Sturgis by his son, Samuel P. Sturgis, hangs in the library. The present collection of 1,500 volumes will be increased to about 3,000 items by the acquisition of additional major American and world-wide contributions to the fields of Hematology.

MSMAS Helps Train Leaders

The St. Clair County Medical Assistants Society was host to the first Leadership Training Seminar for the Michigan State Medical Assistants Society at the Port Huron Motor Inn.

Miss Alice Budny, Milwaukee, past president of the American Association of Medical Assistants, spoke and urged the women to attain even higher levels of accomplishment in their component societies. The purpose of the meeting was to convey to state and local chapter representatives the leadership techniques to solve local problems and build strong chapters. Miss Budny dealt with leadership skills, purposes and goals of a state organization, effective committee work and membership recruitment.

Miss Phyllis Marquardt, President, welcomed the 53 members attending the seminar from various component societies throughout the state. Mrs. Betty Lou Willey, past-president of MSMAS from Port Huron, was chairman of the meeting.

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REVEAL COMMUNITY MENTAL HEALTH PLAN

By the Michigan Department of Health

A comprehensive, long-range plan for the development of community mental health services in Michigan has been approved by the Mental Health and Mental Retardation Facilities Advisory Council.

Following passage of the Community Mental Health Centers Act of 1963, which authorized matching federal funds for construction of local mental health facilities, Governor Romney designated the Michigan Department of Health to administer the program in Michigan, and appointed the 13-member Advisory Council.

The following is the list of service areas programmed for community mental health centers using federal grants authorized under the Community Mental Health Centers Act:

Muskegon, Battle Creek, Flint, South Oakland, Dearborn, Wyandotte, Grand Rapids, Jackson, Kalamazoo, Lansing, Saginaw, Detroit Riverfront, Ann Arbor, Central Detroit, Northwest Detroit, Nankin Township (Wayne County), and Pontiac.

Other service areas will be developed using Hill-Burton funds or state appropriations. These areas, listed by priority ranking, are: Mt. Clemens, Caro, Mt. Pleasant, Petoskey-Alpena, Western U.P., Benton Harbor, South Macomb, Traverse City, Bay City, Port Huron, West Detroit, Marquette, Northeast Detroit, Newberry, Ypsilanti-Monroe, and Northville.

Approximately $6 million will be available for construction of community mental health centers in Michigan during the next three years. The first year's appropriation, nearly $1.5 million, will be allocated on the basis of the state plan to projects which can be under construction early in 1966.

The state plan was developed jointly by the health department's Division of Hospital and Medical Facilities, which is also responsible for administration of federal Hill-Burton hospital construction grants, and the Research, Planning, and Development Division of the Michigan Department of Mental Health.

It represents a total plan for development of community-based psychiatric services under the Community Mental Health Centers Act, the Hill-Burton Act, Michigan's Community Mental Health Facilities Act, and the budget and programming of the state department of mental health.

The plan divides the state into 33 mental health service areas.

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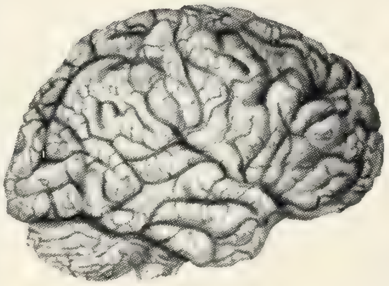

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FACT SHEET ABOUT VOCATIONAL REHABILITATION PROGRAM

By David P. Gage, M.D.
Chief of Medical Services
Division of Vocational Rehabilitation

A recent survey of practicing physicians in Michigan indicated that approximately 95 per cent would like to have more information about the Division of Vocational Rehabilitation and its program. The material to follow represents an effort to condense as briefly as possible the pertinent facts which the State Agency feels the medical profession might appreciate reviewing.

1. The State Vocational Rehabilitation agency retains 12 physicians in the State of Michigan on a contract basis who serve in an advisory and consultant capacity to our nine district offices.
2. State Agency liaison personnel meet at intervals with the Rehabilitation Committee of the Michigan State Medical Society at the request of either group for discussion on problems of mutual concern.
3. The State Vocational Rehabilitation program is presently operating on 33 per cent of its potential budget, even though state funds have been greatly augmented.
4. The State Vocational Rehabilitation program contracts for all medical services in accordance with the Michigan Uniform Fee Schedule as revised by the Fee Committee of the Michigan State Medical Society in July, 1959.
5. This program returns to the state, income taxes that more than pay the total allotted budget. Much additional service can be provided when the state allotment can be increased.
6. The State and District offices welcome referrals from any source. All clients accepted must meet the requirements of financial eligibility except under certain circumstances, for example: counseling and placement.
7. The State Agency program is authorized to provide such basic services as vocational counseling, training, placement (follow-up), medical services including diagnostic services and equipment and tools.
8. The State Vocational Rehabilitation program operates independently although cooperating with the state welfare program.
9. Dedicated to the primary objective of returning every impaired person to maximum productivity, we welcome the opportunity to work with local leaders in developing every possible community resource.

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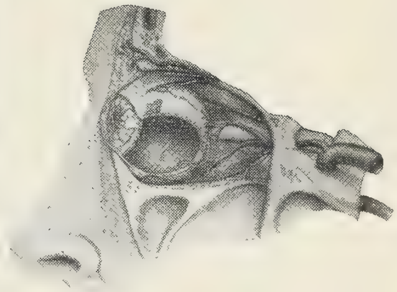

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SOCIO-ECONOMIC

When Can I Stop Buying Insurance

(The following article was prepared by Ben Stratton, MSMS Insurance Counsel, for Michigan Medicine)

"When can I stop buying insurance?"

This is a question that is heard frequently by those of us who make our living by providing for the insurance needs of others. I heard it again recently and it left me with the idea for an article on this subject.

After careful deliberation I would like to submit a reply to this. Here it is: "You can stop buying insurance right now." It would be nice if I could end this on that simple answer, but I realize I have oversimplified the matter and further discussion is needed.

Yes, you can stop buying insurance now, but you must keep on paying for what you have bought, just as you must keep on paying for other necessities. What I am trying to say is: If you will accept a concept of insurance, then you can relax and pay as you go. I would like to ask that you consider accepting the following:

1. Meet your legal responsibility to the public. This means adequate liability insurance, professional, premises, personal and all the miscellaneous types you may require. This also means the limits should be adequate, perhaps up to $1,000,000. The new umbrella policy is well worth looking into if you haven't already done so.

2. Meet your legal responsibility to your employees. This problem is solved simply by maintaining Workmen's Compensation insurance. If you haven't obtained this already, be sure to check the provisions of the new Michigan law. Even domestic employees are now entitled to benefits in many cases.

3. Meet your responsibility to yourself. Protect what you have—your income, your life, your worldly possessions. If it has value, it should be insured. Let's be realistic, however. If the value is negligible perhaps it is better to carry the risk yourself. Also, why not carry policies with higher deductibles and longer waiting periods, thus placing the heavier burden where it belongs—on the insurance carrier.

Perhaps we should discuss life insurance a little more fully because this usually involves the largest outlay of premium dollars.

In the first place, if the life insurance is the permanent type, the premium dollars are not pure expense. A substantial portion becomes the cash value of the policy and is available for emergencies or opportunities and retirement later on, really a sort of savings account.

But to get back to the basic question, here is another concept for your consideration so you may stop buying life insurance. It can be pretty well established that the average physician will require quite a large amount of life insurance during his lifetime.

It is possible to project one's personal situation into the future and to arrive at at least an approximate amount representing the peak need. A good life insurance agent is qualified to help you work this out.

Once you have arrived at the proper amount, take an option on the entire peak need then and there. You can then exercise your option later as your financial situation improves. Perhaps you will never need the entire amount, but it will be there if and when you do.

How is this done? The answer may vary with each individual case, but it is done through the use of low cost term insurance and guaranteed insurability riders and perhaps the use of premium financing. A qualified life insurance agent can arrange the details once you have accepted the concept and established the amount.

Once you are aware of your insurance needs and have accepted the overall responsibility, you really can stop buying. You need only to continue to pay as you continue to pay for the other necessities of life.

OVERHEAD EXPENSE INSURANCE AVAILABLE

Applications are being accepted for the newest MSMS insurance plan—the Professional Overhead Expense Insurance designed to pay your continuing expenses should you become disabled. The insurance would cover such expenses as rent, electricity, heat, water, laundry, employees' salaries, de-

(Continued on Page 598)

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Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

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[illegible]

(Continued from Page 596)

preciation, membership fees and dues, contributions and other normal expenses.

The MSMS Committee on Professional Insurance Plans investigated many overhead expense policies for an entire year.

The Committee points out that while this is a form of disability insurance, it should not replace any insurance you now carry to protect your income. As its name implies, it is intended only to pay overhead expenses. Because of this, premiums are a tax deductible business expense.

An application and explanatory folder has been sent to each member. Extra copies are available from MSMS, Box 152, East Lansing

Blue Shield Explains Special Medical Care Study

Michigan Blue Shield has approved a Special Medical Care Pilot Study for a period of one year or the equivalent in estimated liability.

Effective for admissions on or after July 1, 1965, benefits will be provided for Special Medical Care which is defined to mean such care representing the greater than usual inhospital care.

The Special Care program will be related to a list of acute diagnoses. To qualify for benefits, the physician must submit a report describing the services he considered "greater than usual" and the conditions that prevailed in establishing the acute diagnosis.

A list of acute diagnoses covered by the Pilot Study will be sent to you. However, it is stressed that Special Medical Care does not include prolonged *continuous* bedside attendance because this service is already covered by the prolonged detention benefit.

A benefit of 150 per cent of the present Regular Medical Care benefit for a maximum of the *first five days of medical care,* will be allowed.

When a physician renders Special Medical Care, he should bill Blue Shield on the present Class I Doctor's Service Report, indicating "Special Medical Care, X Days," and attach the report of the case to the DSR form.

Fee Schedule for Special Medical Care Pilot Study Benefits

	Units	A	B	C & D
1st Day	3.75	15.00	18.75	22.50
2nd - 5th Day	1.50	6.00	7.50	9.00

For a five-day period of Special Medical Care, benefits would total 9.75 RV units (3.75 for the 1st day, 1.50 for each of the next four days). This compares with 6.50 RV units for Regular Medical Care.

If prolonged detention (Code 032) is billed on the first day, only four days of subsequent Special Medical Care will be allowed.

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brand of chlorthalidone

the long-acting diuretic

Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

*Swartz, C., et al.: Circulation 28:1042, 1963.

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These insurance company benefits were paid under surgical expense coverages, and under surgical provisions of major medical expense policies.

The Health Insurance Institute also reports that total health insurance benefits by insurance companies last year amounted to nearly $4.7 billion. In addition to surgical coverage, benefits were provided under hospital, regular medical, major medical, and disability income insurance programs.

Squibb Expands Research

The Squibb Division of Olin Mathieson Chemical Corporation has started construction of a multimillion dollar biological research building at New Brunswick, N. Y. The two-story building comprising more than 62,000 square feet will contain the pharmaceutical concern's Toxicology-Pathology Section and will represent a major addition to Squibb's 100-acre research and production complex.

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Prolixin is a dependable tranquilizer that provides your patient with low cost therapy. No other tranquilizer costs less. Safe and convenient for office use—Prolixin in a single daily dose provides prolonged and sustained action. Markedly low in toxicity and virtually free from usual sedative effects—Prolixin is indicated for patients who must be alert. Clinical experience indicates fluphenazine hydrochloride is especially effective in controlling the symptoms of anxiety and tension complicating somatic disorders such as premenstrual tension, menopause, or hypertension—also useful for anxiety and tension due to environmental or emotional stress. When you prescribe Prolixin you offer your patient effective tranquilization that is low in cost, low in dosage and low in sedative activity.

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SIDE EFFECTS, PRECAUTIONS, CONTRAINDICATIONS: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photo-sensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders.

AVAILABLE: 1 mg. tablets. Bottles of 50 and 500.

For full information, see your Squibb Product Reference or Product Brief.

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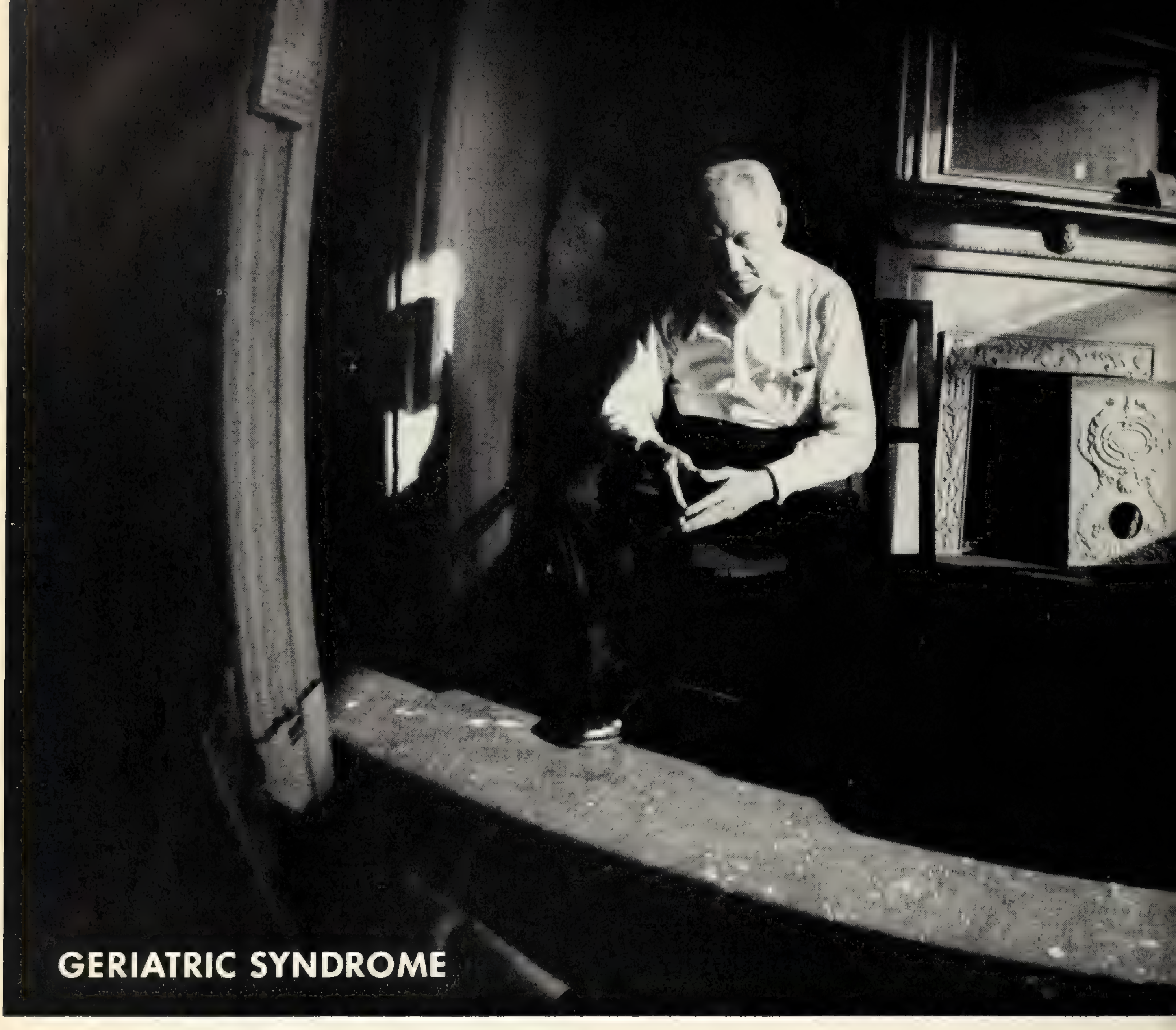

when a change in environment overwhelms him with anxiety

Failing health, financial difficulties, or the death of a spouse are among the reasons why elderly people may be obliged to leave their familiar surroundings. Moving in with children or entering a home for the aged may satisfy practical requirements but can be psychologically traumatic since emotional resilience tends to diminish with age.

Even when anxiety reaches overwhelming proportions, you can counteract it promptly with the potent tranquilizer—Atarax (hydroxyzine HCl).

The outstanding systemic safety record of Atarax makes it particularly suitable for geriatric patients whose drug tolerance is often low. The usual initial dosage in such patients is 50 mg. q.i.d. However, this tranquilizer is so well tolerated that dosage can be adjusted to meet individual requirements. The wide variety of dosage forms allows flexibility of administration from any standpoint—convenience, patient preference, or emergency requirements.

No age, of course, is exempt from anxiety and any number of circumstances can unleash it. Keep Atarax in mind for *all* your emotionally distressed patients—from under 6 to over 60.

for any age—for any stage of anxiety

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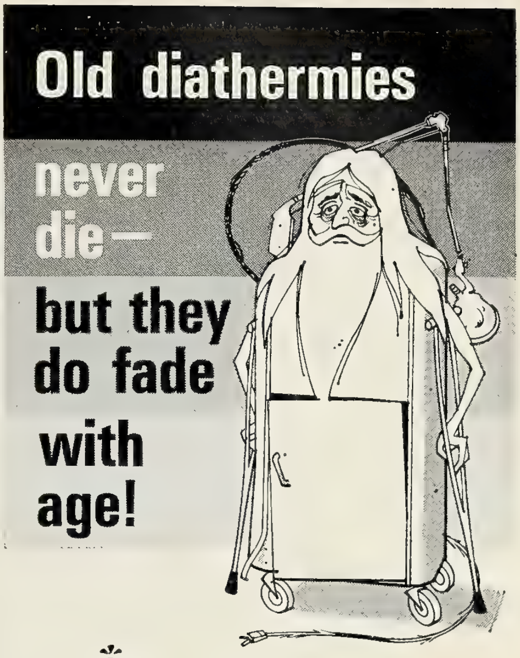
Side effects and precautions: The transitory drowsiness which may occur with hydroxyzine HCl usually disappears spontaneously in a few days with continued therapy, or is correctable by dosage reduction. Dryness of the mouth may be seen with higher doses. Involuntary motor activity has been reported in hospitalized patients on higher than recommended doses. Hydroxyzine HCl may potentiate CNS depressants, narcotics such as meperidine, barbiturates, and anticoagulants. In conjunctive use, dosage for these drugs should be decreased. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. **Parenteral Solution Precautions and contraindications:** This dosage form is intended only for I.M. or I.V. administration and should not, under any circumstances, be injected subcutaneously or intra-arterially. When the usual precautions for I.M. injection have been followed, reports of soft tissue reactions have been rare. I.V. administration should be slow, no faster than 25 mg. per minute, and should not exceed 100 mg. in any single dose. Particular care should be used to insure injection only into intact veins; a few instances of digital gangrene occurring distal to the injection site have been attributed to inadvertent intraarterial injection or periarterial extravasation, both of which should be avoided. **More detailed professional information available on request.**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POSITION OPEN: Pathologist—Associate Depart. Director. PA and CP Certified or eligible. Expanding hospital, with high volume laboratory in Lansing, Michigan. Salary negotiable. Highly challenging position with great potential. Contact: Pathologist, Ingham Medical Hospital, Lansing, Michigan.

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This is not an urgent proposition. I am looking into the future with the idea of finding a well trained associate, possibly within a year, to take over a lucrative practice in 2 or 3 years without financial burden at onset.

Must be trained to do all surgery as I do none.

Please state background, training, references and religious affiliations in contacting. Write Box 10, 120 W. Saginaw, East Lansing, Michigan.

STAFF PHYSICIAN (Michigan Civil Service V Level Position). Immediate vacancies for Staff Physicians at the Southwestern Michigan Tuberculosis Sanatorium, Kalamazoo, Michigan. 200-bed hospital. Salary range $14,365 to $17,539 annually. All Michigan civil service benefits, including an outstanding state contributory insurance program, excellent retirement plan, longevity bonus, and liberal vacation and sick-leave allowance. Should be a citizen of the United States. Must have two years of experience in the practice of medicine and surgery and have or be able to obtain a license to practice medicine in Michigan. Contact Winona Barrows, M.D., Superintendent and Medical Director, Southwestern Michigan Tuberculosis Sanatorium, 1500 Blakeslee Street, Kalamazoo, Michigan. Telephone: FI 5-5171. An equal opportunity employer.

FOR RENT: Office space, 7 rooms completely equipped for Ophthalmologist or Otolaryngologist. Write: W. C. Behen, M.D., 535 S. Capitol Avenue, Lansing, Michigan.

WANTED: Physician for full time hospital duty, Grand Rapids, Michigan. License required. American graduate preferred. Salary open. Liberal fringe benefits including modern home or rental allowance. Write Box #7, 12 W. Saginaw Street, East Lansing, Michigan.

MEDICAL TECHNOLOGIST: ASCP certified or eligible. Modern clinical laboratory. Excellent salary and benefits in a 360-bed, general hospital with large expansion and building program for 1965. Apply: Edward W. Sparrow Hospital, Personnel Office, Lansing, Michigan.

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CAREER SECRETARY with some medical office experience and medical terminology background desires a permanent position in a physicians office. Prefer locating in Ingham or Oakland Counties. Write to Michigan State Medical Journal, Box 11, 120 West Saginaw Street, East Lansing, Michigan.

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references: 1. Winfield, I. W.: Am. J. Gastroent., 31:438, 1959. 2. Blanchard, K.: Rocky Mt. Med. J., 54:527, 1957.

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(warning: may be habit forming)
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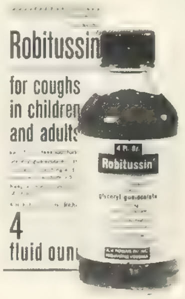
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*Boyd, E.M., and Ronan, A.K.: Am. J. Physiol., 135:383, 1942.

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IN MEMORIAM

VICTOR L. HILL, SR., M.D.

Victor L. Hill, Sr., M.D., 67, Saginaw physician, died June 3 at Saginaw General Hospital.

A native of Traverse City, Doctor Hill was a 1925 graduate of the University of Michigan School of Medicine. He went to Saginaw in 1926 and practiced medicine there until 1960, during which time he was chief of staff at St. Mary's Hospital in 1946 and 1947. He served as physician for St. Vincent's Orphanage for 25 years and as physician for the Saginaw High School Athletic Department for a number of years.

During World War I Doctor Hill served in the U. S. Army.

Doctor Hill was a Retired Member of the Michigan State Medical Society.

Among the survivors is a son, Victor L. Hill, Jr., M.D., of Saginaw.

CLARENCE L. HOOGERLAND, M.D.

Clarence L. Hoogerland, M.D., 45, Alma pediatrician, died May 28 at Community Hospital.

Born in Grand Rapids, Doctor Hoogerland received his medical degree from the University of Michigan School of Medicine in 1944. At the time of his death Doctor Hoogerland was health officer for the City of Alma.

Doctor Hoogerland was a member of the Western Michigan Pediatric Society and the Gratiot County Association for Retarded Children.

During World War II Doctor Hoogerland served with the U.S. Army Medical Corps from 1945 to 1947.

RALPH A. JOHNSON, M.D.

Ralph A. Johnson, M.D., 59, a past-president of the Wayne County Medical Society and former chief of staff of Jennings Memorial Hospital, died June 26 at his residence.

Born in Park River, N. D., he moved to Detroit when a boy. Doctor Johnson was graduated from the University of Michigan School of Medicine in 1929 and interned at Harper Hospital. He also studied under fellowships at New York Hospital and Peter Bent Brigham Hospital in Boston, specializing in internal medicine and cardiology. His hospital affiliations included Jennings, Harper, Bon Secours and Receiving. Doctor Johnson practiced medicine in Detroit since 1934.

Long active in medical affairs, Doctor Johnson was treasurer of the Wayne County Medical Society at the time of his death. He served his county society as editor of the *Detroit Medical News* for many years. He was a former delegate to the Michigan State Medical Society, and also was a former delegate to the American Medical Association. Doctor Johnson was active on many MSMS committees and served on the original MSMS Relative Value Study Committee.

A member of the Detroit City Plan Commission, of which he was president last year, Doctor Johnson also had served as president of the City Welfare Commission, as a member of his area draft board and director of the medical aspect of Detroit's civil defense program in World War II.

HENRY P. KOOISTRA, M.D.

Henry P. Kooistra, M.D., 60, consultant in surgery at St. Mary's Hospital in Grand Rapids, died May 27 at that hospital.

Born in Burum, The Netherlands, Doctor Kooistra came to Grand Rapids in 1911. He received his medical degree from the University of Michigan School of Medicine in 1931 and was awarded a master of science degree in general surgery from that school in 1940. In 1941, his paper on "Pilonidal Sinuses" won the Foster Foundation award of St. Mary's Hospital.

Doctor Kooistra was a Life Member of the American College of Surgeons, a Fellow of the International College of Surgeons and a member of the American Society of Abdominal Surgeons and the Michigan Association of the Professions. At the University of Michigan he was among the founders and the first president of Phi Alpha Kappa and a member of Phi Kappa Phi honorary fraternity. Doctor Kooistra was also a charter member of Pine Rest Foundation.

The first chairman of the Kent County Cancer Detection Center, Doctor Kooistra also served as a liaison member of the Disaster Committee of the Kent County Red Cross Chapter.

Among the survivors is a son, William H. Kooistra, M.D., chief psychologist at Pine Rest Christian Hospital, Grand Rapids.

FRANK E. LUTON, M.D.

Frank E. Luton, M.D., 86, longtime St. Johns doctor, died June 20, in Clinton Memorial Hospital.

Born in Belmont, Ontario, Canada, Doctor Luton was graduated from The Michigan College of Medicine and Surgery in 1901. Doctor Luton began his medical practice in Huron County, and after 10 years moved to Clinton County where he served 40 years. He was a former chief of staff of the Clinton Memorial Hospital. He retired in 1958, but returned to practice when he moved to Beaver Island. He was a staff member of the Charlevoix Hospital.

In 1951 Doctor Luton was granted the Michigan State Medical Society 50 Year Award and was a Life Member of MSMS.

WILLIAM H. MORRISON, M.D.

William H. Morrison, M.D., 53, Genesee County Medical Examiner, died May 16 at St. Joseph Hospital in Flint.

A native of Illinois, Doctor Morrison received his medical degree from the Hahnemann Medical School, Philadelphia, Pennsylvania. Doctor Morrison practiced medicine in Illinois, Indiana and Ohio before coming to Michigan. After a year at Goodrich Hospital in Flint, where he made his home, he opened a practice in Grand Blanc from 1950 until the time of his death. Doctor Morrison was on the staffs of St. Joseph, McLaren General, Genesee Memorial and Hurley Hospitals.

Doctor Morrison was a member of the American Academy of General Practice.

During World War II Doctor Morrison served in the U. S. Army for two years, including duty in Egypt, Arabia and Germany.

EARL POTTER, M.D.

Earl Potter, M.D., 54, retired L'Anse physician, died May 3 at his residence in Riverside, California.

Doctor Potter was born in Vancouver, British Columbia, Canada, and received his R.N. degree in 1932 from the Hinsdale School of Nursing in Hinsdale, Illinois. He later received his M.D. degree from the College Medical Evangelists, Loma Linda, California. Doctor Potter interned at Edward Sparrow Hospital, Lansing, and practiced medicine and surgery there for 14 years. He moved to L'Anse where he was on the staff of the Baraga County Memorial Hospital for 10 years.

Doctor Potter was a member of the American College of Surgeons and a Retired Member of the Michigan State Medical Society.

During World War II Doctor Potter served in the Navy in the South Parific area for three and one-half years.

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FRANK W. PRATHER, M.D.

Frank W. Prather, M.D., 61, Milford physician, died May 20 at Pontiac General Hospital.

A native of Dayton, Ohio, he received his medical degree from the University of Cincinnati. He served his internship and residency at Miami Valley Hospital, Dayton. Following postgraduate work at the University of Michigan, Doctor Prather entered private practice at Yale, Michigan, where he remained for 17 years before moving to Milford.

Doctor Prather's memberships included Sigma Nu Fraternity, Alpha Kappa Honorary Medical Fraternity, the Michigan Heart Association and the Oakland Unit of the Michigan Cancer Foundation, serving on its board of trustees.

A veteran of World War II, Doctor Prather served overseas in the European Theatre for three and one-half years and retired as a Major of the U. S. Medical Corps in 1946.

BENJAMIN F. SEABROOKS, M.D.

Benjamin F. Seabrooks, M.D., 63, Detroit physician for 33 years, died May 25 at Woodward General Hospital, Highland Park.

Doctor Seabrooks received his medical degree from Meharry Medical College in Nashville, Tennessee. He was a member of Omega Psi Phi fraternity.

A son, Franklyn Seabrooks, M.D., resident at Woman's Hospital, is among his survivors.

EDWIN L. THIRLBY, M.D.

Edwin L. Thirlby, M.D., 85, Michigan's "Foremost Family Physician of 1960" and a longtime Traverse City doctor, died June 9 at Munson Medical Center.

Doctor Thirlby was born in Grand Rapids and received his medical degree from the University of Michigan School of Medicine in 1903. Following two years of postgraduate surgical training in London, England, he began his long medical career in Traverse City in 1906.

Active in civic and community affairs, Doctor Thirlby served as mayor of Traverse City in 1930 and received the Distinguished Citizen award in 1932.

In 1953 Doctor Thirlby was granted the 50-Year Award by the Michigan State Medical Society, which named him "Foremost Family Physician" in 1960. He received the Regents' Citation of Honor from the University of Michigan in 1961.

Doctor Thirlby, a Fellow of the American College of Surgeons, was a sponsor of the annual Coller-Penberthy-Thirlby Conference held in Traverse City each year.

Doctor Thirlby was a Life Member of the Michigan State Medical Society.

Among the survivors is a son, Richard L. Thirlby, M.D., of Traverse City.

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Reporting As Ordered

A MONTHLY COMMENTARY

By Hugh W. Brenneman

EXECUTIVE DIRECTOR

> "It is not only arrogant but profligate for a man to disregard the world's opinion of himself."—Cicero

Cicero's words are true a thousand times over when applied to an organization.

Because no organization can exist for 100 years in secrecy, or without serving a very real public need, it follows that it would do well to display itself favorably by reviewing the service it has to offer.

That is what the Michigan State Medical Society proposes to do in celebrating its 100th birthday September 19-24, 1965. It will take advantage of this celebration to say "thank you" to the many segments of society that have either served—or served with—the medical profession. At the same time it will indicate its future plans.

132 Scientific Experts Coming to Speak

What are the dimensions of the Centennial Session? Here are some figures that indicate its proportions:

- During the six-day meeting 132 scientific speakers will be heard.
- An additional 500 persons will participate in some manner in the programs, either to chairman a meeting, receive an award, accept an introduction, etc. Nearly 100 of this group will be non-medical speakers who will address special audiences on subects of interest contiguous to medical science and medical practice.
- Over 1,500 associations of one variety or another are being contacted to participate in the meetings.
- Speaking of meetings, the gavel will call to order 152 meetings during the six days.

Invite Alums of 72 Med Schools to Meet

- The alumni groups of 72 medical schools have been asked to meet during the Centennial—many of them will.
- 197 awards will be presented.
- There will be 75 receptions, 52 dinners, 125 technical exhibits and 50 scientific exhibits. MSMS exhibits will cover 500 square feet of space in Cobo Hall.
- In addition, aligned with these exhibits, will be an art exhibit of works by doctors and their wives, while closely tied in will be a special exhibit at the Detroit Institute of Art of art owned by doctors.

In addition to the support received from exhibitors MSMS will receive financial support totaling some $20,000 from Parke, Davis & Co., Upjohn, and the alumni groups of medical schools.

The mountains of paper work involved in putting this program together are practically incalculable. At least 20 million times, some newspaper, television set, radio speaker, poster, billboard, pamphlet or letter will carry a part of the story of the Centennial.

Special Health Mobile To Be Dedicated

A 50-foot special trailer featuring 1,200 square feet of exhibits will be unveiled. Before its year-long journey has ended, it will have traversed 10,000 miles and been visited by an estimated 350,000 persons in 55 counties.

Only an estimate can be made of the total amount of money invested in this program, but if the money spent in attendance is added to the money spent in preparation for the attendance the total should approximate $1,150,000.

Participating in this as teachers and learners will be some 20,000 people, consisting of doctors of medicine, their families and guests from 30 different states.

It is no mean task to weave this pattern and have it blanket this geographic area of the medical world. It would be tedious to relate the mountain of details involved.

And All This Planned For Individual MD

The most important factor is that the planning committee headed by C. Allen Payne, M.D., has one person in mind in its total effort—the individual doctor of medicine who is a member of the Michigan State Medical Society.

The plans are made so that he will be exposed to the finest collection of medical learning possible to cram into a six-day period and in turn, his state organization will be exposed to the public gaze revealed as it truly is—an organization of men of science dedicated to serve the public good.

What day or days are you planning to attend? Have you made your hotel reservation? Did you block out this period on your appointment calendar? Has your wife been informed of the opportunities for her? Will your medical assistant have an opportunity to visit the show?

Each Day a Convention in itself . . .

CENTENNIAL SESSION

SUNDAY, SEPTEMBER 19
Medicine and Religion Day

MONDAY, SEPTEMBER 20
Medicine and Business, Industry and Communications Day

TUESDAY, SEPTEMBER 21
Medicine and Medical Organization Day

WEDNESDAY, SEPTEMBER 22
Medicine and Science Day

THURSDAY, SEPTEMBER 23
Medicine and Voluntary Health Day

FRIDAY, SEPTEMBER 24
Medicine and Government Day

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Centennial Session

September 19-24, Detroit

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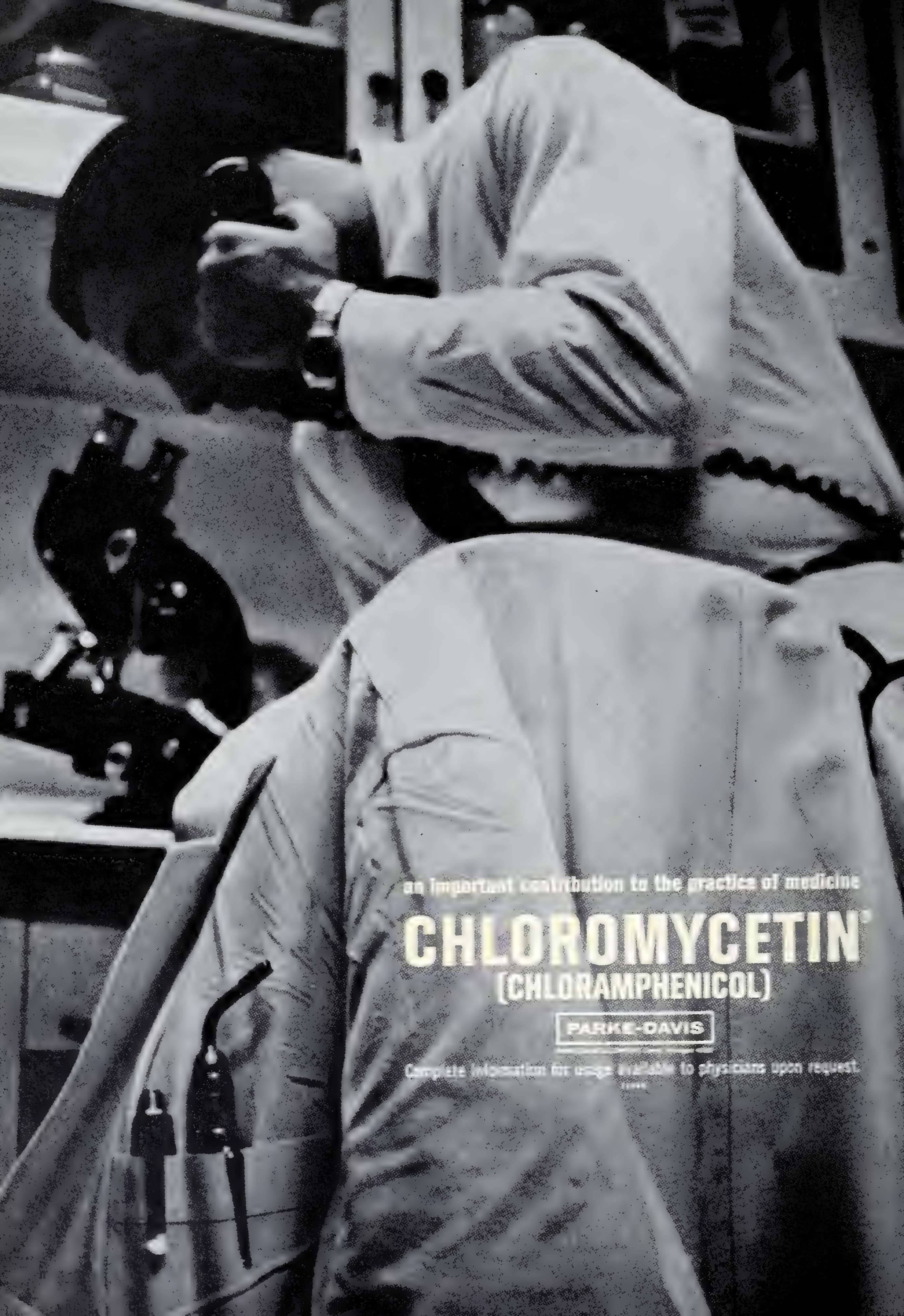

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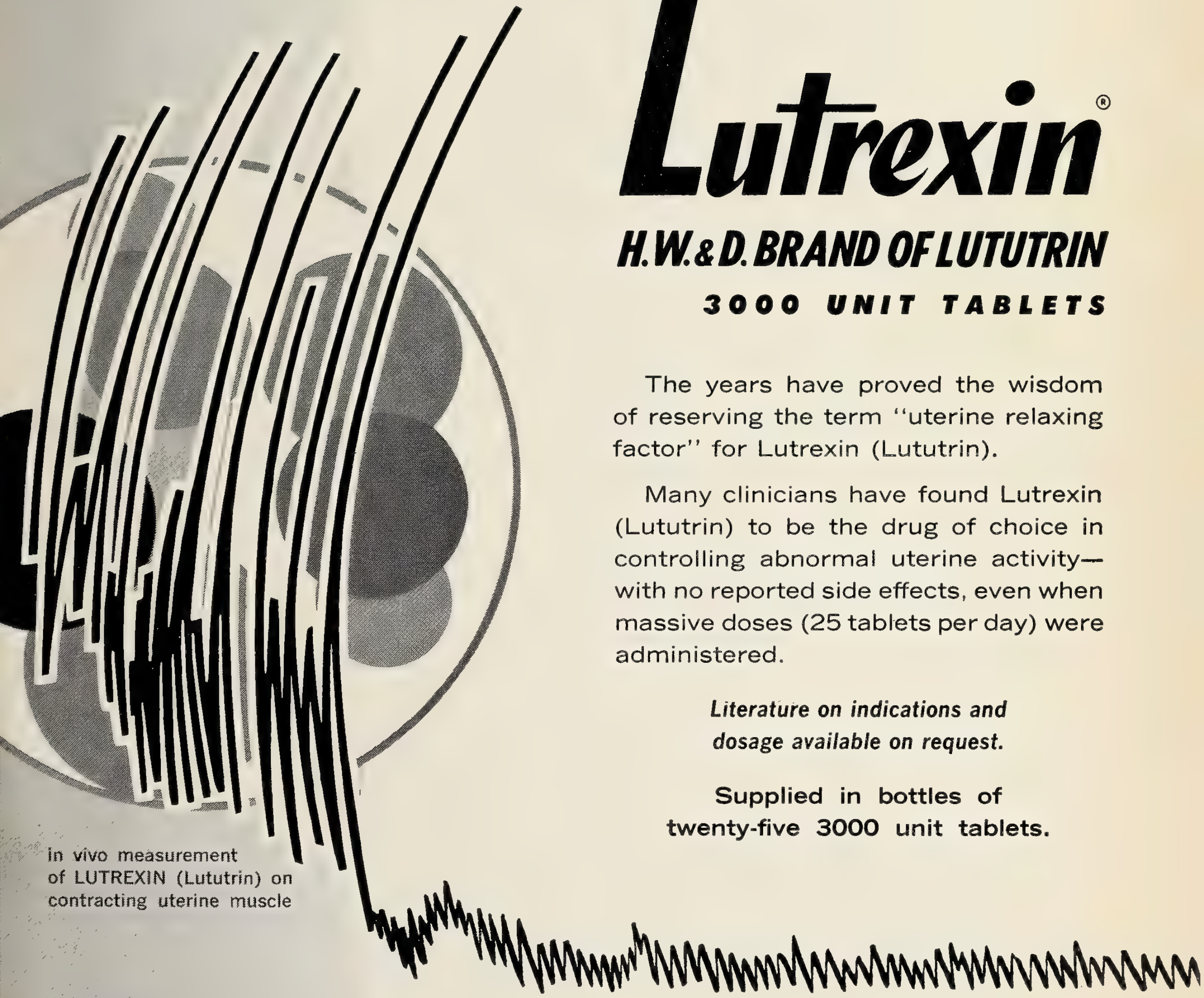

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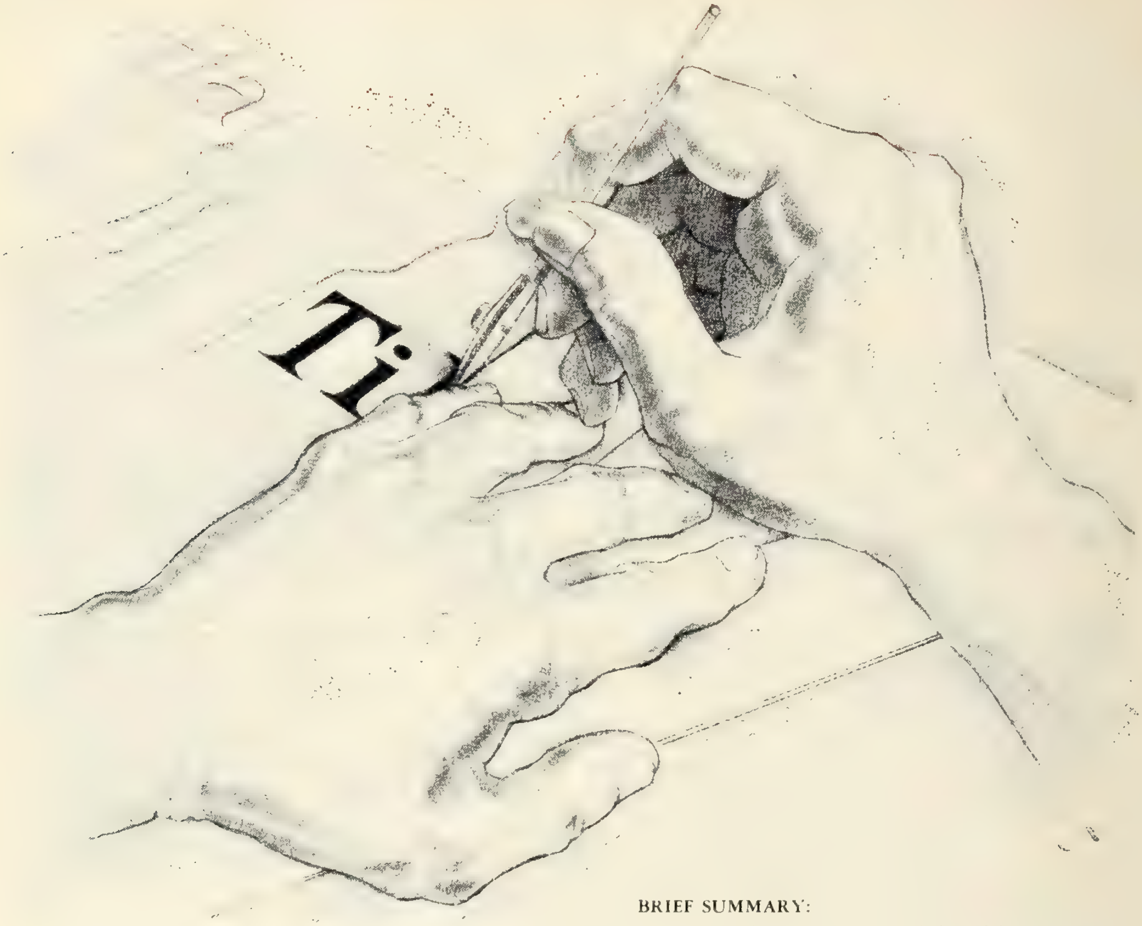

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the president's message . . .

Your Obligation

Are you one of the many fine doctors who is bewildered by the obvious antipathy of the public to doctors in general?

Are you one who blames the AMA and your State Medical Society for this attitude?

If you are, then you had better re-examine your own attitude. Both the AMA and your State Medical Society are **you.**

If they are not you, then that is your fault. If you think they are being directed by medical politicians, a term of derision by some, that is your fault too.

When I was elected president of your Medical Society, I stated to the House of Delegates that I doubted if I could ever repay organized medicine for the chance it had given me to practice medicine free of socialism. **You,** too, have had this opportunity because of the efforts of organized medicine.

We may well be losing this freedom to practice good medicine undeterred by bureaucratic interference. We are not losing it because of the AMA but in spite of the most dedicated battle ever waged by any organization. We are losing it because of the election of a majority of liberals who are pledged to foster the principles of the Welfare State.

And let's face it, because a large number of citizens are willing to trade their liberty for the prospect that the federal government will pay their health bills.

The war for good medicine is not completely lost of course just because one battle appears hopeless. Organized medicine will fight on. But organized medicine in the past has represented doctors the majority of whom have not lifted a finger except to pay their dues. If you are one of those doctors who at last realizes that the gratitude of your patients is not enough, then it is your obligation to take an active part in organized medicine.

If these organizations are not representing you, doctor, **you** can change them to your image.

Oliver B. McGillicuddy, M.D.

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9. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

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Warning: If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Side effects
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Contraindications
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient cannot be seen regularly, when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin® alka are contraindicated in patients with glaucoma.

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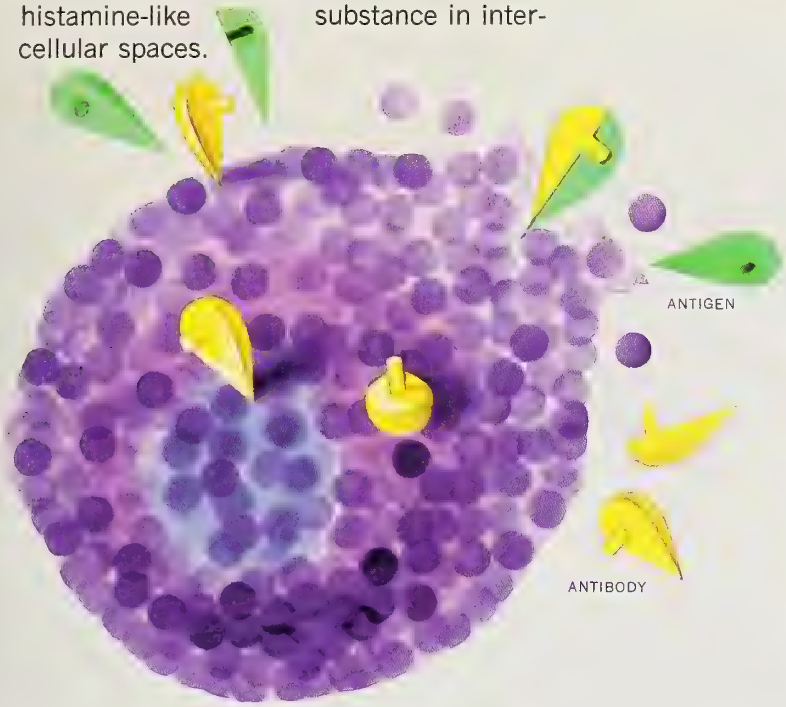

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*Schiller, I.W. and Lowell, F.C.: New England J. Med. *261*:478, 1959.

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It has been noted that low-back disorders frequently "...are caused by truly mechanical conditions which yield to conservative treatment."[1] Basic to this conservative treatment are bed rest, a board for the bed, and applied heat. In addition, a good muscle relaxant is often helpful, as "...muscle relaxants are useful in chronic as well as acute low backaches."[4]

Robaxin (methocarbamol) has relieved spasm and pain in cases where the patient "had not responded to conservative measures prior to drug therapy."[6] A 100-patient study showed that Robaxin provided greater relief of muscle spasm for a longer period of time without adverse reactions "than any other commonly used relaxants...."[6]

A well-tolerated[7] skeletal muscle relaxant with "specificity of action,"[7] methocarbamol leaves normal muscle tone unaffected. Moreover, there is little likelihood of sedation[7]—a considerable advantage for the patient who must remain active and alert on his job.

Significantly, clinicians advise using a muscle relaxant "early and in adequate dosage."[8] In this regard, Robaxin (methocarbamol)—*particularly in the 750 mg. dosage (2 tabs. q.i.d.)*—offers optimal therapeutic benefits without a significantly increased incidence of side effects. And just as it works well as part of the basic regimen for low-back pain, so also does Robaxin (methocarbamol) often provide muscle relaxation in such conditions as musculoskeletal injury, chronic neurological disorders, and orthopedic situations.

BRIEF SUMMARY—Robaxin (methocarbamol) Tablets: Contraindicated in hypersensitive patients. Side effects (light-headedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently.

ALSO AVAILABLE: Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)

Robaxisal® (methocarbamol with aspirin) and Robaxisal-PH Tablets (methocarbamol with Phenaphen®).

REFERENCES: 1. Soto-Hall, R.: Med. Sci. *14*:23, 1963. 2. McCarrol, H.R.: Paper read at the Annual Meeting of the American Medical Association, Atlantic City, June 16-20, 1963. See Medical News: J.A.M.A. *185*:39 (July 13), 1963. 3. Gordon, E.J.: Med. World News *5*:54, 1964. 4. Cozen, L.: GP *26*:82, 1962. 5. Larson, C.B.: Postgrad. Med. *26*:142, 1959. 6. Forsyth, H.F.: J.A.M.A. *167*:163, 1958. 7. Weiss, M., and Weiss, S.: J. Amer. Osteopath. Ass. *62*:142, 1962. 8. Rowe, M.L.: J. Occup. Med. *2*:219, 1960.

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Reporting As Ordered

A MONTHLY COMMENTARY

By Hugh W. Brenneman
EXECUTIVE DIRECTOR

After months of planning and almost a plethora of good ideas the Centennial Session of the MSMS is taking shape. The mountain of details to complete prior to the Big Week seems insurmountable. But the week will come and the work will be done and the MSMS will have had the finest Centennial of any state ever. Probably the largest group of Michigan doctors ever to assemble together will have participated in this great meeting when it finally winds up.

Meantime, preparations for the coming year are being considered:

Healthmobile to Boost Community Relations

1. The work of the special Judiciary Commission headed by Past President Orlen J. Johnson will culminate in a change of organizational structure and a program second to none in the nation.

2. The MSMS Healthmobile moving to 55 areas in the state will be the mechanism around which an effective community relations program will form. Ralph Wills of our staff, Tony Doherty and Frank Catto of the Michigan Health Council, and Russell Cheadle of the AMA have been working on plans to give this birth. Vic Hogg of the Frank and Stein architectural firm is to supervise the installation of the backgrounds and exhibits. At the moment this Healthmobile appears to be the finest tool yet devised to put together a state-county society effort that will adapt to any size community and be worthy of the attention and support of public, patients and physicians.

3. MICHIGAN MEDICINE in its reconstituted image is receiving kudos from across the nation. Even more importantly, it is now attracting more advertising. We seem to have scored a turn around in its financial support. We've been asked to moderate a national symposium in Chicago on the subject. But there is so much more which can and will be done with this communication facility—the use of color, special editions and additions, humor, piggy-back sections, etc., etc.

Better Communications A Constant Challenge

4. Our communications with members of MSMS leaves much to be desired. A pretty good job is being done via the printed word (MICHIGAN MEDICINE with its hot news section, MEDIGRAM, Advice—Information—Data, Special Legislative Bulletins, letters, etc.) and we have our share of meetings, telephone and personal contact. But we haven't used two great media which could be very effective, i.e., radio and television. These can be used in closed or open circuit form. Each can provide a two-way flow of information directly from the MSMS to each of its members. Effort is being made to obtain foundation support for the installation of a state-wide network. The PR Committee has recommended it. Doctor John Sheldon has urged its support and The Council has approved it—subject to the obtaining of the finances from other sources.

5. Postgraduate educational activity is stepping up. There can never be enough of it. This year witnessed more and better symposiums and seminars on the community-by-community basis. Next year this effort increases in direct proportion to the appreciation it receives. Doctor H. A. Towsley and his committees have been working very hard in the whole PG area with staff members, Herb Auer and Helen Schulte, following through.

6. Services of MSMS directly to its component societies and its individual members have been growing in number and improving in quality. But a new modality has been added to the organizational armamentarium—the computer. What can it do for us? Just wonders, that's all—providing we learn how to use it. Some of the brainstorming that has gone on in this category sounds fantastic. But the computer fellows say it's practical. Not tomorrow; right now!

Next time you see Doctor Stapleton, MSMS Historian, congratulate him. His writing excellence caused The Council to put into hard-cover book form the series of articles detailing the 100 year life of the MSMS, which he wrote for MICHIGAN MEDICINE. They'll be sold for a dollar—and that's a bargain for this limited edition publication. The Assistant MSMS Historian, William LeFevre, M.D., has done a similar and equally fine job on the Muskegon area.

Council to Study Medicare Implementation

The Council quietly assigned, on at least a temporary basis, the Advisory Committee to the executive director the responsibility of studying Medicare and its implementation in Michigan.

MSMS will be working on this one for many years. All doctors must, perforce, be alert to the law and its regulations. The State Society will help, but there will be local problems for local solution.

We grieved at the passing of Gordon Goodrich. He had served the profession for 20 years in Michigan, working mainly for Michigan Medical Service, and for the past year or so for the Michigan Hospital Service. Generously he gave many days of his time to the Michigan Health Council as its treasurer for 16 years.

Bill Burns, long time MSMS Executive Director, became a grandfather on July 21 when his beautiful daughter Missy (she is Mrs. Frank Mack of Arlington, Virginia), gave birth to Elizabeth Ann. Bill enjoys the breezes on the 17th floor of his condominium in Fort Lauderdale, and says Jo and he are having a wonderful summer; offered best wishes for a great Centennial, and commiserations to the staff for the extra work.

Lirugen(TM)

is *truly* a one shot measles vaccine.

An efficacy rate of 99% has been demonstrated with Schwarz Strain live measles vaccine (Lirugen). In recent clinical trials, Lirugen was administered without gamma globulin to approximately 13,000 children. In 1,405 of these children tested serologically, a conversion rate of 99% was reported. Close medical follow-up of inoculated children and controls showed no significant differences between mean maximum temperatures in the two groups. The incidence of high fever (103°F and above, rectally) attributable to the vaccine could be calculated at less than 1%, and the occurrence of mild, transient rash at less than 3%.

Lirugen is the most highly attenuated, but fully antigenic, live measles vaccine. Additional special passages of the original Edmonston Strain by Schwarz resulted in further attenuation which reduces systemic reactions so effectively that the use of gamma globulin with Lirugen is not needed.

Contraindications: Pregnancy; leukemia, lymphoma and other generalized malignancies; brain damage in children under one year of age; febrile illness; allergy to egg proteins, neomycin, or streptomycin. Precautions: Use cautiously in patients with a history of tuberculosis and patients being treated with steroids, irradiation, alkylating agents, and antimetabolites. Consult package literature before administering Lirugen.

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1. Schwarz, A.J.F.: Amer. J. Dis. Child., **103:** 386-389, 1962.
2. Krugman, S. et al.: Pediatrics, **31:** 919-928, 1962.
3. Andelman, S. L. et al.: J.A.M.A., **184:** 721-723, 1963.
4. Measles Vaccines: W.H.O. Technical Report Series No. 263, 1963.
5. Schwarz, A.J.F.: Annales Paediatrici, **202:** 241-253, 1964.
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IN MEMORIAM

ZINA B. BENNETT, M.D.

Zina B. Bennett, M.D., 73, Detroit physician-surgeon for nearly 50 years, died July 2 in Doctors Hospital where he was medical superintendent.

A native of Detroit, Doctor Bennett received his medical degree from the Chicago College of Medicine and Surgery in 1916. His father, the late John F. Bennett, M.D., served as coroner and school inspector in Detroit. Doctor Bennett's hobby was magic and he was well known as an amateur magician.

Doctor Bennett was affiliated with Maybury Grand Hospital in Detroit. His specialty was industrial surgery and medicine. He was a member of the Detroit Academy for Surgery of Trauma and Nu Sigma Nu Medical Fraternity.

During World War I Doctor Bennett served as a captain in the U.S. Medical Corps.

Doctor Bennett was a Life Member of the Michigan State Medical Society.

EARL A. HASTY, M.D.

Earl A. Hasty, M.D., 62, director of Michigan Public Health Unit No. 2, died July 12, at his residence in West Branch.

Born in Sterling, Doctor Hasty was graduated from the University of Michigan School of Medicine in 1929. He interned at St. Mary's Hospital in Saginaw and then entered private practice in Whittemore in 1930. He remained in Whittemore until 1947, when he moved to West Branch and built Hasty Clinic.

Former chief of staff of Tolfree Hospital, Doctor Hasty retired from active practice in 1957, when he assumed duties as public health director in Iosco, Ogemaw, Alcona and Oscoda Counties.

ALONZO A. NORCONK, M.D.

Alonzo A. Norconk, M.D., retired internist, died July 4, at his home in Empire, at age 64.

Born in Empire, Doctor Norconk was graduated from the University of Michigan School of Medicine in 1901 and practiced internal medicine in Detroit until his retirement in 1958.

Doctor Norconk's hospital affiliations included Grace Hospital, Detroit, and James Decker Munson Hospital at Traverse City.

During World War II, Doctor Norconk was a commander in the United States Navy and served on the hospital ship, Tranquility.

HAROLD C. ROBINSON, M.D.

Harold C. Robinson, M.D., 72, Grand Rapids physician for more than 40 years, died June 28 at Blodgett Memorial Hospital.

A native of McComb, Ohio, Doctor Robinson was graduated from Harvard Medical School in 1923. He took his internship and residency at Blodgett Hospital, Grand Rapids, and helped found the Cardiac School Clinic there and served as its cardiologist for 30 years.

A diplomate of the American Board of Internal Medicine, Doctor Robinson was also a fellow of the American College of Physicians. Other affiliations included the American Hospital Association and the Family Service Association of Kent County.

During World War I, Doctor Robinson served with the Army Air Service before he attained his medical degree.

GABRIEL STEINER, M.D.

Gabriel Steiner, M.D., 82, retired Wayne State University professor of neuropathology, died August 10, in Jennings Hospital, Detroit.

A native of Ulm, Germany, Doctor Steiner was a graduate of the University of Strasbourg. He taught there and at the University of Heidelberg before joining the faculty of Louisiana State University in 1936. Doctor Steiner joined the Wayne faculty in 1937 and retired in 1953. He then became director of the Multiple Sclerosis Center in Detroit, a position he held until retiring in 1958.

Doctor Steiner was appointed a member of the medical advisory board of the National Multiple Sclerosis Society when it was organized in 1947. In addition to research into multiple sclerosis, he also conducted research into tumors and nodules and he had several treatises published on these experiments.

Doctor Steiner was a Life Member of the Michigan State Medical Society.

"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.

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ASPIRIN
FAST PAIN RELIEF
ORANGE FLAVORED
BAYER
ASPIRIN
CHILDREN

Dear Alumnus:

Please turn your calendar ahead and place a large maize-and-blue check on the dates of October 14–16, 1965. This will mark the Third Annual Reunion of our Medical Center Alumni: a lively mixture of fun, sports and science designed exclusively for graduates of the Medical and Nursing Schools and those who trained at University Hospital. There also will be special programs for the wives and husbands of returning graduates.

The program committees have given us these highlights of the scheduled events:

THURSDAY, OCTOBER 14: Individual programs for each of the "'five-year" classes ('20, '25, '30, '35, etc.)

FRIDAY, OCTOBER 15:
Physicians—All day scientific program.
Nurses—Program on modern nursing practices.
Wives—Program in Ann Arbor and Dearborn.
Husbands—Visit to U-M Space Research laboratories (just dedicated by Astronauts McDivitt and White) and other points of interest.

SATURDAY, OCTOBER 16: Homecoming Football, U-M vs. Purdue.

On the social side there will be the customary luncheons, dinner, reception and dance to help make your visit a pleasant one.

Meanwhile, to get the jump on the Homecoming crowd, we urge you to make your own arrangements for housing. Each of the following motels have rooms set aside for us. Write them directly and mention "Medical Center Alumni Reunion."

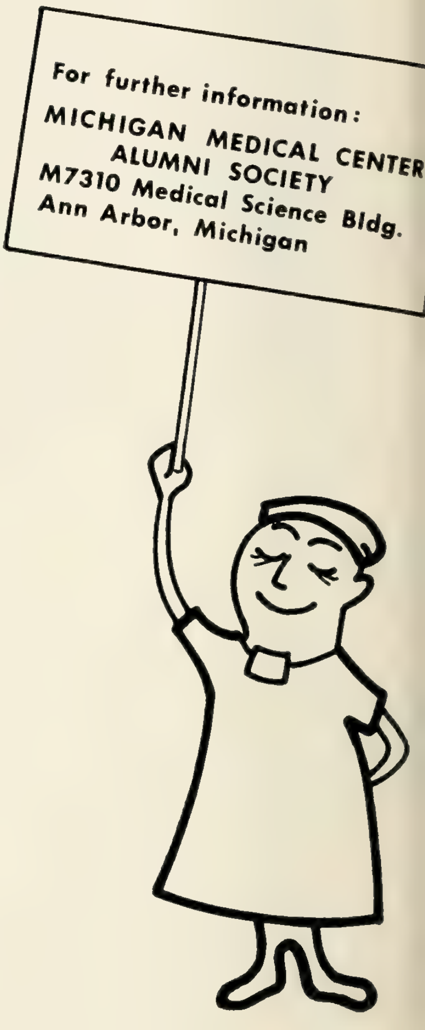
Arbor Lodge, 3245 Washtenaw; Bell Tower, 300 South Thayer; Holiday Inn, 2900 Jackson Road; Howard Johnson, 2380 Carpenter Road; Lamp Post Motel, 2424 East Stadium; Michigan League, 227 South Ingalls Street; Michigan Union, 530 South State Street; Stage Stop Motel, 2433 Carpenter Road; University Motel, 1000 Broadway.

We hope this will give you sufficient notice to budget your time for the Reunion, for we all look forward to having you with us.

Sincerely yours,

George Morley

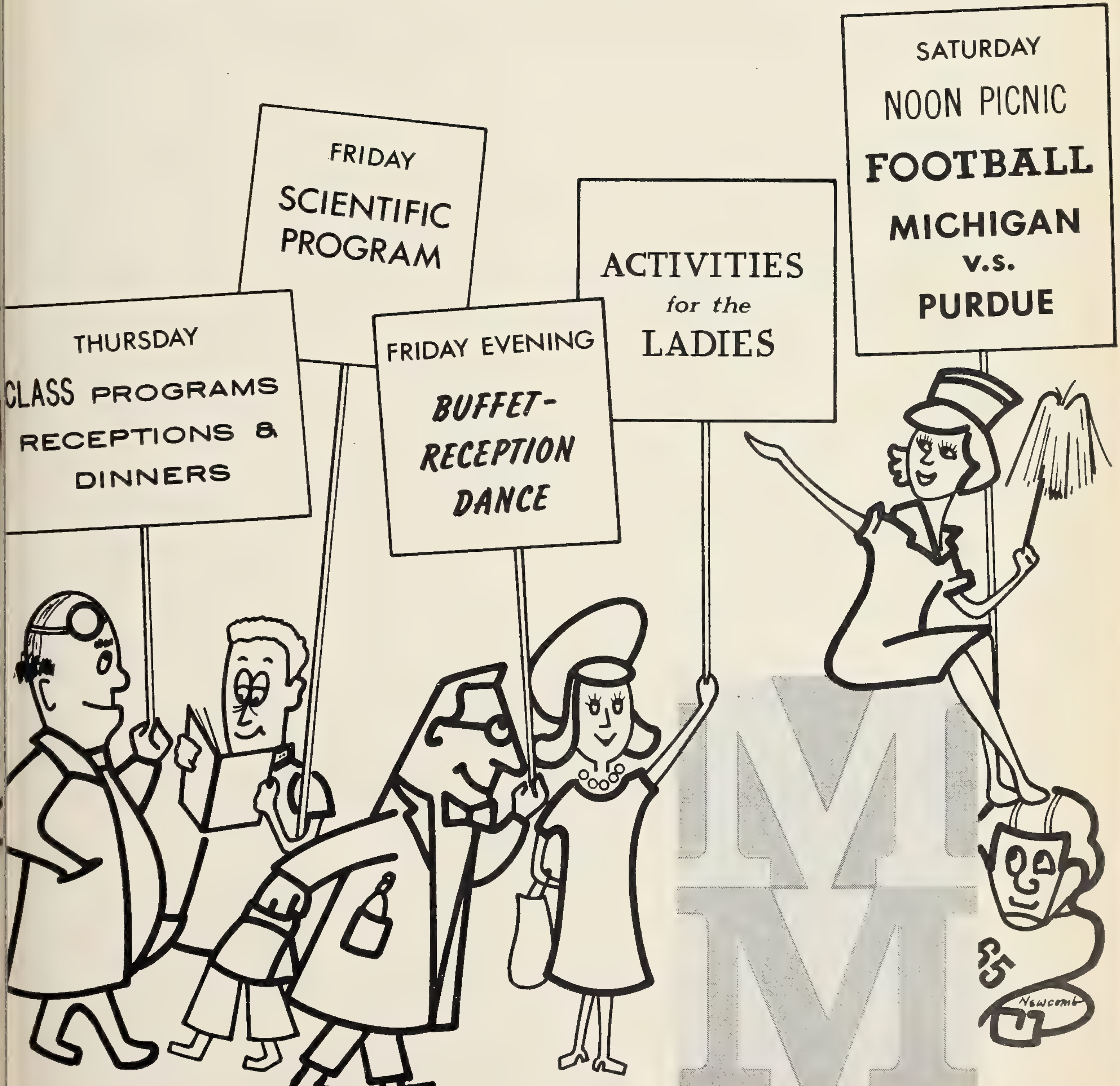
George Morley, M.D.
Chairman, Publicity



THE UNIVERSITY OF MICHIGAN MEDICAL CENTER ALUMNI SOCIETY

CONFERENCE - 1965

OCTOBER 14, 15, & 16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CLASS PROGRAMS
RECEPTIONS &
DINNERS
FRIDAY
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BUFFET-
RECEPTION
DANCE
ACTIVITIES
for the
LADIES
SATURDAY
NOON PICNIC
FOOTBALL
MICHIGAN
V.S.
PURDUE
M
65
Newcomb

Progress and Promise

As we join in celebrating this state-wide medical centennial, we extend our congratulations to the physicians of Michigan and to their professional associations. We congratulate them on a century of progress and on its promise for the future.

During the past hundred years, the world has witnessed an unparalleled advance in medicine. More and more the interconnected labors of laboratory and clinic have gained new heights for "the science and the art" of healing.

To this advance, you members of the Michigan medical community have offered your share of skill and devotion—in practice, in research, and in teaching. Your high standards of scientific and humanistic endeavor have animated the progress of medicine in Michigan.

As part of the professional community, we of The Upjohn Company are proud to have contributed research and service; and we look forward to a continuing participation.

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AMA Delegates Ask Communications Be Continued

Federal health care legislation, the report of the President's Commission on Heart Disease, Cancer and Stroke, and The Gundersen Committee report on organization of the House of Delegates were among the major subjects acted upon by the 1965 AMA House of Delegates in New York City.

Charles L. Hudson, M.D., native of Merrill, Michigan, and now of Cleveland, a member of the AMA Board of Trustees since 1961, was named president-elect of the association.

James Z. Appel, M.D., of Lancaster, Pa., was inaugurated in New York as president for 1965-66.

Most controversial issue before the House was that of nonparticipation under any so-called "Medicare" law that might be passed by Congress. The House recommended that "the members of the American Medical Association be reminded that it is each individual physician's obligation to decide for himself whether the conditions of a case for which he is about to accept responsibility permit him to provide his own highest quality of medical care."

The House also declared that "the physicians of the United States of America pledge themselves to continue their search and activity, in whatever social environment may develop, to secure or to restore the freedom, high quality and availability of medical care which has been traditional in our country."

* * *

THE HOUSE restated its offer "to meet with the President of the United States through our Legislative Task Force to discuss proposed medical care legislation with a view to safeguarding the continued provision of the highest quality and availability of medical care to the people of the United States."

The House instructed the AMA "to make every effort to continue, and where necessary, to expand its communication activities so that all physicians as members of component medical societies will be promptly, continuously and completely informed of developments in this critical area during the coming months."

Seven resolutions involving the report and recommendations of the President's Commission on Heart Disease, Cancer and Stroke were presented and the House adopted a substitute statement which resolved in part that:

"The American Medical Association points with pride to the immense strides made in the approaches to the conquest of heart disease, cancer, and stroke under existing patterns of research and medical practice; strongly favoring the use of available financial support for extension of these patterns rather than replacement by a complex of medical control centers and satellites."

Action on the Gundersen Committee report reviewing the size, make-up and functions of the House of Delegates was postponed until the 1965 Clinical Convention in Philadelphia.

* * *

THE HOUSE OF DELEGATES also:

Urged medical schools and agencies concerned with continuing education to incorporate "appropriate learning experiences" for physicians in counseling relating to sexual attitudes and behavior.

Agreed that hospital medical staffs and state and component medical societies be urged to encourage the establishment, maintenance, and proper use of cancer registries in hospitals, but that the establishment of such registries should not be made a requirement for accreditation by the Joint Commission on the Accreditation of Hospitals.

Instructed the Council on Medical Services and its Committee on Federal Medical Services to "remain alert to any deviations from policies of the Veterans Administration concerning the provision of drugs to veterans treated by private physicians, and to meet with pharmacy representatives so that the basic principle of freedom of choice" of pharmacists be maintained.

Reaffirmed its policy concerning the practice of radiology, pathology, anesthesiology and physical medicine in hospitals.

Reaffirmed AMA policy that human blood, as living tissue, should not be purchased under insurance contracts.

Urged state and local medical societies to encourage the development of the Explorer Scout Program for Medical Specialty Posts.

Adopted a resolution calling for continued efforts to secure the passage of legislation "which will remove tax discrimination against professional people, specifically HR 10 (Keogh) and HR 697 (Weltner), but turned down recommendations that the AMA encourage its members to proceed at the state and county levels with the formation of corporations for the purpose of implementing an "organized effort in the courts to remove tax discrimination."

Directed the Board to study the opportunities and problems associated with Operation Head Start and other programs now operating or planned under the Economic Opportunity Act.

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Contraindications: Hyperexcitable and prepsychotic states; patients hypersensitive to meprobamate.

Side Effects: Occasional allergic skin reactions may occur with meprobamate, accompanied by fever, nonthrombocytopenic purpura, angioneurotic edema, hypotension, or bronchial spasm. Drowsiness with or without ataxia and/or alteration in visual accommodation may occur. Effects of alcoholic beverages may be increased by meprobamate. Use with caution in patients with coronary or cardiovascular disease or severe hypertension. Prolonged use may result in dependence. Reactions can occur if drug is not withdrawn gradually.

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See our exhibit at the Centennial Session in Detroit

Readers Write

Dear Dr. McGillicuddy:

Today the July issue of MICHIGAN MEDICINE arrived and I read, with interest and pride, your tribute to the Woman's Auxiliary and the Michigan State Medical Assistants Society.

We are proud of our doctors in Michigan and the wonderful job they are doing in our communities. We accept your challenge "to do even more to enhance the total medical profession."

Because we believe that the only justification for the existence of our Society is improvement in the medical assistant's performance on the job, we are striving to provide the best educational opportunities for our members. We are seeking to promote public relations. We wish to provide the physician with qualified employees because we believe in American medicine. Ultimately this will improve patient care. It is imperative that we cling to these ideals even though the government has encroached on the private practice of medicine.

The cooperation and assistance we have received from MSMS has been inestimable and we want you to know we appreciate it. We are also appreciative of the counsel we have received from our advisors.

Thank you for every kindness you have shown to me and to our Society. We are indeed indebted to you and we sincerely hope we will continue to merit your support and confidence.

Sincerely yours,

(Miss) PHYLLIS MARQUARDT, *President*
Michigan State Medical Assistants Society
Kalamazoo, Michigan

All of us on the Pennsylvania Medical Journal consider your publication one of the very best among the many we receive.

DOROTHY J. LUDY
Editorial Assistant
Pennsylvania Medical Journal

Robert E. Rice, M.D.
Greenville, Michigan

Dear Doctor Rice:

The July issue of *Michigan Medicine* came to my desk today and I want to commend you on your excellent article which appeared in the editorial section.

The title of the article "Doctors Wanted for Small Towns" was very appropriate and your discussion of the various areas of concern in physician distribution as well as suggested activities to improve the situation was well done.

BOND L. BIBLE, PH.D., *Secretary*
Council on Rural Health, AMA

Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

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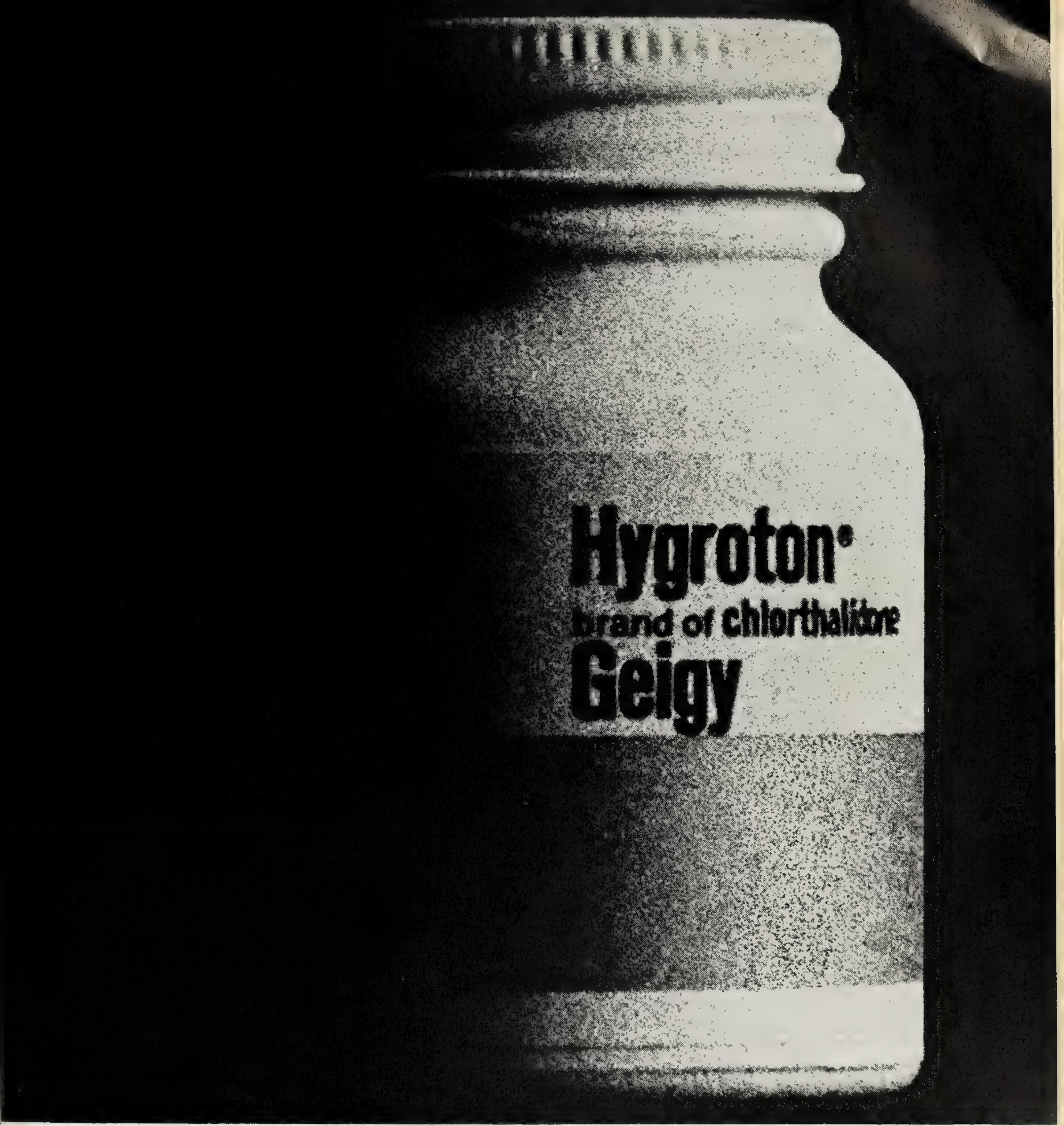
Say you saw it in Michigan Medicine



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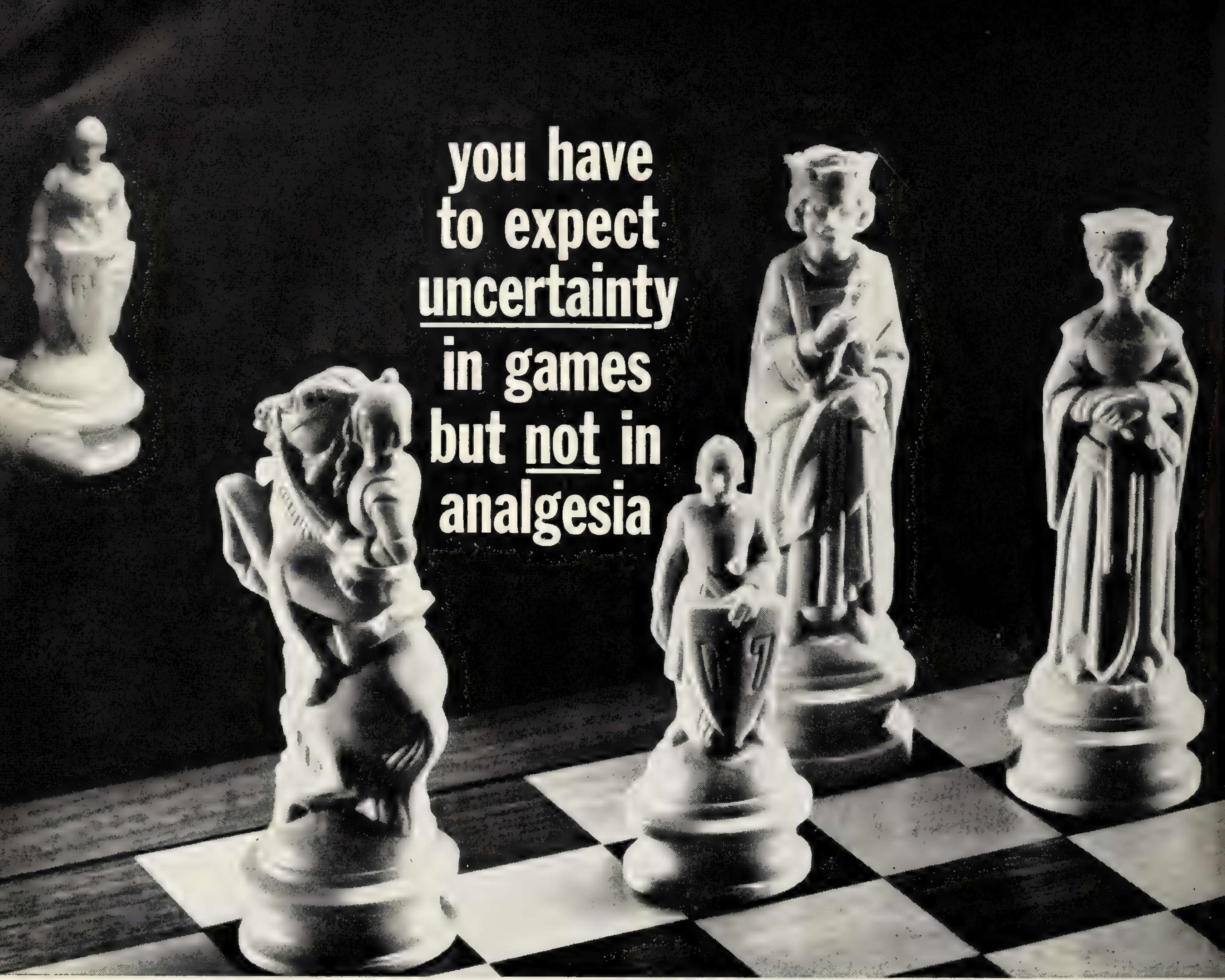
Patients with edema.
Edema in congestive heart failure.
Or in the premenstrual syndrome.
Edema in pregnancy...or obesity.
Patients you want to bring to dry weight.
And those you want to keep at dry weight.
Those you want on single daily doses.
And those requiring even fewer doses.
Those resistant to other therapy.
And those intolerant of other diuretics.
Those who have to pinch pennies.
And those who can afford the best.


you have to expect uncertainty in games but not in analgesia

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Precautions, Side Effects and Contraindications—The habit-forming potentialities of PERCODAN are somewhat less than those of morphine and somewhat greater than those of codeine. The usual precautions should be observed as with other opiate analgesics. Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias.

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NEWS BRIEFS

A. F. Litzenberger, M.D., Bay City, spoke about "The New Mother after Delivery" on the Michigan Health Council television program over WWTV and WWUP-TV at Cadillac and Sault Ste. Marie recently.

The "Decisions" television program of the Michigan Association of the Professions over WJBK-TV, Detroit, recently featured **Royal Hayden, Jr., M.D.**, Detroit, on a program about "Hearing and You."

The recent Medical Association of Georgia seminar on "Medical Aspects of Sports" used two Michigan speakers—**Richard C. Schneider, M.D.**, Ann Arbor, and **Robert W. Bailey, M.D.**, Port Huron.

The Beth Tephilath Moses synagogue recently honored **Joseph Scher, M.D.**, Mt. Clemens, as "Father of the Year." About 150 attended the testimonial dinner. Doctor Scher received an engraved ceremonial wine cup for his work as a physician and humanitarian.

Michigan physicians are invited to a symposium on "Genetic Studies Among the Amish" at Bluffton, Indiana, at 1:30 p.m., September 29. Reservations should be sent to the Wells County Medical Society at Bluffton.

The AMA Conference on Medical Aspects of Sports, November 28, in Philadelphia will include several Michigan physicians: **E. S. Gurdjian, M.D.**, Detroit, and **Gerald A. O'Connor, M.D.**, and **Richard C. Schneider, M.D.**, both of Ann Arbor.

Mayors, city managers and other officials at the National League of Cities Convention in Detroit visited the Wayne State University Department of Occupational and Environmental Health.

Dean Ernest Gardner, M.D., of the Wayne State University School of Medicine, spoke in Wiesbaden, Germany, at the 8th International Congress of Anatomists meeting. In September he will travel to Paris to participate in a symposium to study the normal pathological development of the hip joint.

Andrew J. Smith, Jr., M.D., Detroit, is president of the Michigan College Health Association.

Edward H. Heneveld, M.D., and **William C. VanGelder, M.D.**, both of Muskegon, spoke at the 11th annual meeting of the Flying Physicians Association, at Miami Beach. The association, founded to promote general aviation safety and to explore the various medical disciplines as they relate to aviation, has 1,700 members in all 50 states.

Blodgett Hospital, Grand Rapids, now has an established Department of Research with **Vernon E. Wendt, M.D.**, as the director. He formerly was WSU assistant professor of medicine and director of the cardiac laboratory at Detroit Receiving Hospital. Doctor Wendt continues as assistant professor at the Wayne State University School of Medicine.

Sheldon N. Siegel, M.D., has been appointed as the new assistant medical director of The Haven Hospital and Psychiatric Center, Inc., Rochester, Michigan. Doctor Siegel fills the position which was previously held by **Lawrence Koltonown, M.D.**, who is going into private practice in Southfield. At the same time, **Michael Kaprielian, M.D.**, joins the medical staff of The Haven as a fulltime staff psychiatrist.

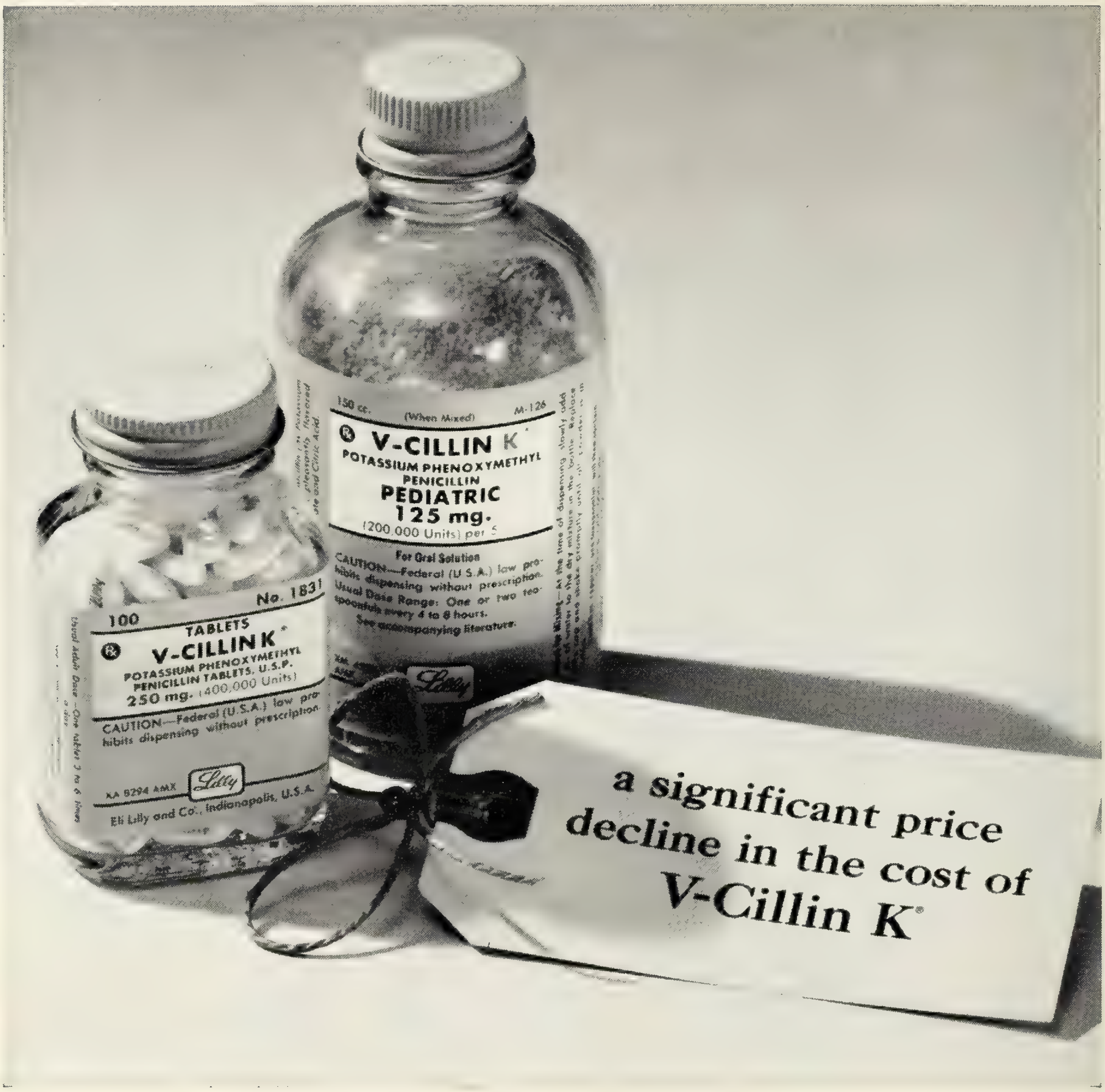
E. T. Palm, M.D., formerly of Crystal Falls, was one of two winners of the $1,000 Ross Awards presented by the American Academy of General Practice in recognition of outstanding scientific writing. Doctor Palm wrote an article, "Palliative Management of Metastatic Carcinoma of the Breast" in the April issue of GP. He left Crystal Falls to serve a residency in surgery at Swedish Hospital, Minneapolis.

Credits

In preparing this special Centennial Session issue, MSMS received excellent cooperation from several organizations and firms which gave MICHIGAN MEDICINE permission to use art work and photographs.

Deep appreciation is extended to the Michigan Medical Service for use of the excellent David Stone Martin original illustration on the cover, and also for sketches on pages 690 and 691.

Sincere thanks are extended also to the American Medical Association, for photographs and/or sketches on pages 646, 680, 681, 682, 687, 694, 695, 696; University of Michigan, 685 and 686; The J. L. Hudson Company, 697; Burton Historical Collection, Detroit Public Library, 701; and AMA Today's Health, 683.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A Good Result

AMALGAMATION OF OSTEOPATHS AND PHYSICIANS IN CALIFORNIA

BY

JOSEPH P. COSENTINO, M.D.
SACRAMENTO, CALIFORNIA

The amalgamation of osteopaths and physician M.D.'s in California has been accomplished because of a united interest to place all physicians on a sound educational and scientific basis and to pursue a course of unification that will give the citizens of California the finest in the promotion and protection of the public health.

The assimilation of former osteopaths into county medical societies in California virtually has been completed. This marks the culmination of the efforts of many over a number of years to amalgamate the two professions in that state.

As a former osteopathic physician, I have been asked by a number of physicians and osteopaths to write a paper setting forth some of the highlights of the merger and the current problems resulting from it.

* * *

THIS MERGER DID not take place as a result of activities of California physicians and osteopaths over just a few years. Rather, this was the culmination of the activities of the liaison committees of the California Medical Association and the California Osteopathic Association. For a period of 30 years these committees had been working on mutual problems.

The Agreement

The merger jelled, however, with an agreement entered into by the CMA and COA in May, 1961. The intent of this agreement was to remove any distinction amongst the physicians practicing medicine and surgery in California in relation to skill and ability, to make available to the public at large adequate hospital facilities with unlimited consultation and to improve the educational facilities for those individuals practicing medicine and surgery in the State of California.

The necessary changes in the constitution and bylaws of the two associations were ratified in 1962 by unanimous vote.

Medical Society Membership

It was agreed that the former D.O.'s should join the county medical societies where they resided. But each county medical society is autonomous. Accordingly, as an intermediate step in August, 1962, the CMA issued a charter to a state-wide organization, the Forty-First Medical Society. A total of 2,176 former D.O.'s who obtained an M.D. degree from the California College of Medicine were eligible for membership in this society, the CMA and the AMA.

The Forty-First Medical Society enjoyed all the

SCIENTIFIC PAPERS

rights and privileges of any component medical society of the CMA. The Forty-First Medical Society had 21 delegates in the CMA House of Delegates. Two members of the Forty-First served as counselors to the CMA Council. Many members of the Forty-First Medical Society served on CMA committees and commissions. One former D.O. was appointed to serve on the Board of Medical Examiners by the Governor of California. Another has been elected an alternate delegate to the AMA House of Delegates.

* * *

THE LOCAL MEDICAL societies have been processing the transfer of the members of the Forty-First. Of necessity, this has been a time-consuming program. All parties had agreed that the very same procedure should be used by the membership committees of the various county medical societies as is used by them for any other transferee from another component medical society.

The most formidable problem has been the assimilation of the former D.O.'s into the various branches of the Los Angeles County Medical Society. The reason for this is that there were about 1,350 former D.O.'s in this county. About 1,250 of them applied for membership in LACMA. Of the 100 who have not applied, about one-fourth to one-third are in the retirement age. Twelve applications have been deferred. The remaining applicants, 1,238, have been transferred to LACMA.

Approximately 650 former D.O.'s residing elsewhere in the state have been transferred to their local county medical societies.

The College

In May, 1961, the Board of Trustees of the College of Osteopathic Physicians and Surgeons voted to cooperate with the unification program. They directed the administrative officers of the college to organize a program for the issuance of M.D. degrees to persons properly qualified. The Board of Trustees instructed the president to apply for accreditation, which involved seeking approval of the Liaison Committee on Medical Education of the AMA and the Association of American Medical Colleges and membership in the AAMC. In addition, the Board took the necessary steps to change the college's name to the California College of Medicine.

The college became an accredited medical school in February, 1962. It was approved by the California Board of Medical Examiners in February, 1962.

Only those D.O.'s who held the unlimited California licenses of physician and surgeon were eligible to convert their degrees to M.D. By September 30, 1962, the deadline for issuing such degrees, the college had granted 2,696 M.D. degrees to former osteopaths.

Since then, many full and part-time faculty appointments have been made.

The new medical school has continuing affiliation with a 500-bed hospital of the Los Angeles County Hospital System. Also negotiations are nearing completion for affiliation with the University of California. This will assure for the California College of Medicine continued financial stability.

* * *

PRESENTLY, THERE are 350 students in the college. The school accepts 96 new students each year. Prior to the merger, the school annually received applications from between 200 and 250 students. In the fall of 1963, as an M.D. school, the college received 632 applications. A total of 855 applications were received for admission to the college in the fall of 1964.

The graduates of the college are afforded the same opportunity for postgraduate training as are graduates of other medical schools.

The Hospitals

A number of the 63 former osteopathic hospitals in the State of California either have been granted accreditation or are in the process of making application for accreditation to the Joint Commission on Accreditation of Hospitals.

Many of the members of the Forty-First have been accepted for membership on the staffs of medical hospitals throughout the state. Their appointment to the staff has been made solely on the basis of individual skill and ability.

Internships and Residencies

As part of the California unification program, on May 9, 1962, the Council on Medical Education of the American Medical Association issued a statement providing that the former D.O. who had received an M.D. degree from the California College of Medicine could be appointed to approved internship and residency programs located in the State of California.

On July 9, 1962, the Council on Medical Education issued a statement of "Eligibility of Osteopathic Physicians for Appointments in Approved Intern and Resident Programs in Federal Hospitals" which provided in part as follows:

> "It is therefore the policy of the Council that former osteopathic physicians who have received an M.D. degree from the California College of Medicine and who are fully licensed are eligible for appointment as interns or resi-

dents to approved programs in any Federal hospital without jeopardy to the approved status of such programs."

Specialty Certification

A problem, not fully resolved, involves the matter of certification of the former D.O. specialists. This difficulty was anticipated at the time of the merger agreement. The CMA promised to do what it could to obtain certification for the former D.O. specialists. The CMA has honored its pledge.

In addition, the CMA established a Certifying Review Committee. This committee reviewed the background and training of the former D.O. specialist. Those specialists whose background and training were found to be in order received a certificate to that effect from the committee. Those individuals who were in residency training or had completed residency training but had not had a sufficient period of time to be eligible for their examination by the osteopathic specialty board, have been given a certificate by the California Certifying Review Committee stating that their post-graduate education background has been reviewed and documented.

The specialty boards of the AOA withdrew their certification of the D.O. who retained his M.D. degree from the California College of Medicine.

The M.D. specialty boards are considering the eligibility of former D.O.'s who now hold M.D. degrees. On July 16, 1962, the American Board of Surgery issued the following statement:

> "It will be necessary for the Examination Committee to consider individually the qualifications of candidates who are graduated from the California College of Medicine . . . prior to the class of June, 1962."

In April, 1964, the American Board of Anesthesiology took the following action:

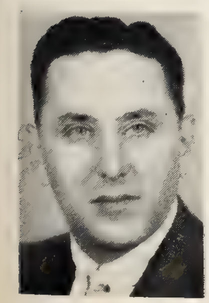
> "A former Doctor of Osteopathy who has been granted the degree of Doctor of Medicine by the California College of Medicine in Los Angeles, and who is licensed as a Doctor of Medicine in any state, will be considered to have met the medical school requirements of the Board and may be admitted to its examinations, provided his other credentials are found to be acceptable."

The hurdles facing former D.O. specialists are the requirements of the M.D. specialty boards that an individual be a graduate of an approved medical school and have an approved internship and residency. Former D.O. specialists cannot meet these requirements.

I hope that in time the M.D. specialty boards will determine a former D.O.'s eligibility for certification on the basis of his knowledge and ability and place considerably less emphasis on where his training has been obtained.

Conclusion

As a former D.O., I believe that a good result has been achieved in this merger for former osteopathic physicians, patients and the community. More importantly, the graduates of the California College of Medicine will have available to them all of the opportunities for postgraduate training that is available to all graduates of approved medical schools. This will redound to their own benefit and to the benefit of those whom they are called upon to treat.



THE AUTHOR

Joseph P. Cosentino, M.D.

Coming In October

The October issue of Michigan Medicine will feature articles of interest to general practitioners, orthopedic surgeons, internists, dermatologists, and public health.

Authors from Detroit, Chicago, New York City, Jackson, Lapeer and Saginaw present their contributions to the medical literature on topics ranging from total body occlusive treatment with topical steroids to the genesis and sequelae of automobile accidents. Drs. Ross V. Taylor and Joseph A. Preston from Jackson present an outstanding evaluation of serum enzyme tests and electrocardiographic changes in diagnosis of acute myocardial infarction, and Dr. John O. Goodsell of Saginaw, reports on the resilient radial nerve.

These and other interesting scientific presentations will be well worth your time in October.

Replacement of the Intrapericardial Aorta For Dissecting Aneurysm with Aortic Regurgitation

Two patients were treated for severe acute aortic valve regurgitation caused by dissecting aneurysm of the intrapericardial aorta. In both patients, replacement of the ascending aorta with a dacron prosthesis after resection of the diseased aorta was sufficient to restore competence of the aortic valve. It was not necessary to replace the aortic valve in either patient.

By

THOMAS GAHAGAN, M.D.
ELLET H. DRAKE, M.D.*
BOTH OF DETROIT

Dissecting aneurysm of the ascending or intrapericardial aorta may distort an otherwise normal aortic valve and produce signs of severe aortic valve regurgitation.

We have recently operated on two patients with this condition. One patient had a silent onset of aortic regurgitation associated with a febrile illness. The other had an acute, painful onset more typical of dissecting aneurysm.

Both patients were relieved of their aortic regurgitation by resection of the aneurysmal ascending aorta and dacron prosthesis replacement without replacement of the aortic valve itself.

Case No. 1

A 54-year-old man had a complete physical examination, which was reported as normal in the fall of 1963. Six months later he noticed gradually increasing shortness of breath and his physician, Frank Prokop, M.D., noted the appearance of a loud systolic and diastolic murmur in the aortic area and along the left sternal border, which had not been present previously. The blood pressure was 120/60-40. The patient had no history of rheumatic fever and the blood serology was negative.

The onset of the symptoms and murmurs was associated with a fever of 102° F. X-rays taken at this time showed enlargement of the heart and plethoric lungs. Although repeated blood cultures were negative, it was thought that bacterial endocarditis probably had caused aortic valve leaflet destruction. The patient was treated with penicillin and streptomycin as well as digitalis and continued to run a fever of about 99.8° F.

* * *

PHYSICAL EXAMINATION six weeks following the onset of symptoms showed the precordial activity and peripheral collapsing pulses typical of aortic valve insufficiency. Cardiac catheterization was carried out, and contrast material injected into the root of the aorta clearly demonstrated massive regurgitation through the aortic valve. It was noted at the same time that the ascending aorta had an unusually large caliber which was thought to be somewhat inconsistent with the short history of the illness, but no further significance was ascribed to it at the time.

At operation on March 2, 1964, for repair of the aortic valve, a tremendously dilated, very thin-walled ascending aorta was encountered. After beginning total heart-lung bypass with a pump oxygenator and cross clamping the aorta just proximal to the origin of the innominate artery, an incision was made into the dilated ascending aorta. This incision entered the outer channel of a dissecting aneurysm filled with fluid blood and communicating with the main channel of the ascending aorta by a tear approximately 1 cm in width located on the postero-lateral aortic wall about 3 cm above the aortic valve ring.

The dissection had progressed from this point both distally toward the innominate artery and proximally toward the heart so that some of the aneurysm actually overlapped the heart. The aortic valve leaflets, though pushed together by the aneurysm, were individually completely normal. The coronary arteries were perfused with oxygenated blood while the ascending aorta from the aortic valve ring to the innominate origin was resected. The double channel was sutured together both proximally and distally and the ascending aorta was replaced with a prosthesis of dacron (see illustrations on following pages.) Upon removing the aortic clamp and stopping the pump, the blood pressure was recorded at 142/90.

The patient's postoperative recovery was without significant complications and he was discharged from the hospital on the twenty-second postoperative day.

He was readmitted to the hospital on September 9, 1964, with the complaint of pain in the left shoulder and back. Chest x-rays showed a suspicious lesion at the left apex which on retrospect was identified on previous films. A left postero-lateral thoracotomy was performed and an unresectable superior sulcus tumor (poorly differentiated epidermoid carcinoma) with chest wall and hilar invasion was found. The patient was treated with cobalt irradiation and was considerably relieved of his discomfort. His blood pressure and cardiovascular status remained excellent. He died on January 29, 1965, presumably of terminal cancer although an autopsy was not performed.

CO-AUTHOR
Thomas Gahagan, M.D.

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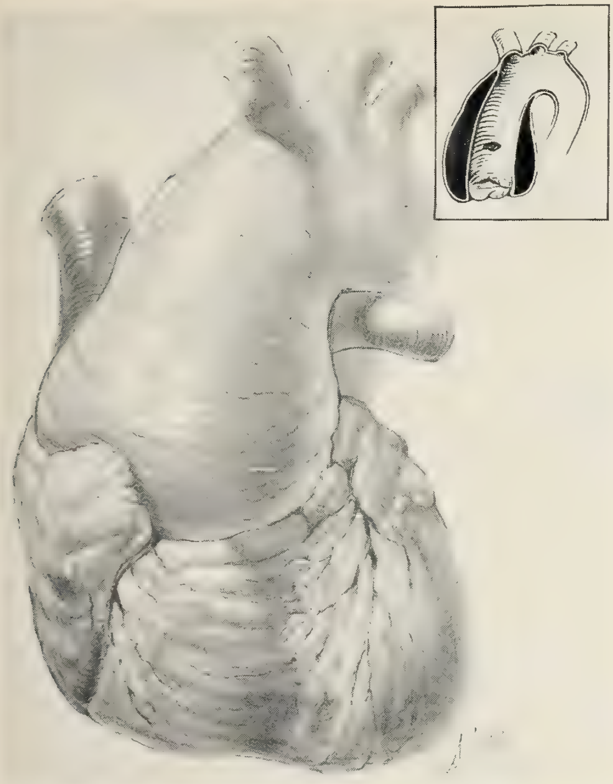
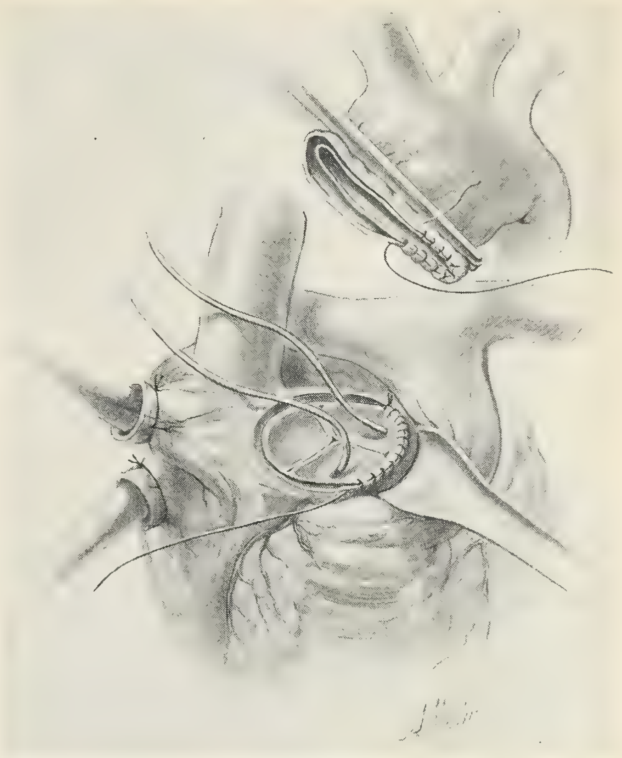
*From the Divisions of Thoracic Surgery and Cardiology, Henry Ford Hospital, Detroit, Michigan.

Presented at the November 20, 1964, meeting of the Detroit Heart Club.



Gross appearance of dissecting aneurysm of the intrapericardial aorta as seen at the operating table. The tremendous dilatation of the ascending aorta completely obscures the main pulmonary artery.
Inset: The diagram shows the tear in the aortic intima allowing passage of blood into the aortic wall to produce the aneurysm. The pressure of the blood in the false lumen directed against the base of the aorta, distorts the aortic valve cusps to allow aortic regurgitation.



With cardiopulmonary bypass and coronary artery perfusion, the ascending aorta is resected. The split aortic wall is sutured together around the aortic valve ring and proximal to the innominate artery prior to insertion of a pre-clotted dacron graft.

Case No. 2

The patient, a 56-year-old man, had episodes of transient, mild chest pain beginning in November, 1961. However, his general health was good until May, 1964, when just after beginning his evening meal, he had a sudden onset of severe pain in the back. This radiated to the front of the chest and into the shoulders. The pain was extreme for about half an hour. The patient noted along with it weakness and sweating. Although the pain increased with deep breathing, there was no dyspnea or hemoptysis.

The patient was admitted to Metropolitan Hospital that evening by Dr. Robert R. Cubberly who noted that although the patient's blood pressure was previously 130/80, the pressure on admission was 170/50, and in addition, there was a very loud systolic murmur over the whole precordium with a diastolic murmur along the left sternal border.

Retrograde aortograms were done at Metropolitan Hospital on June 13, 1964, and the patient was subsequently transferred to the Henry Ford Hospital. The findings on admission here were roughly the same, although the blood pressure was recorded as 140/35-15 and the pulse was described as being of the water-hammer type.

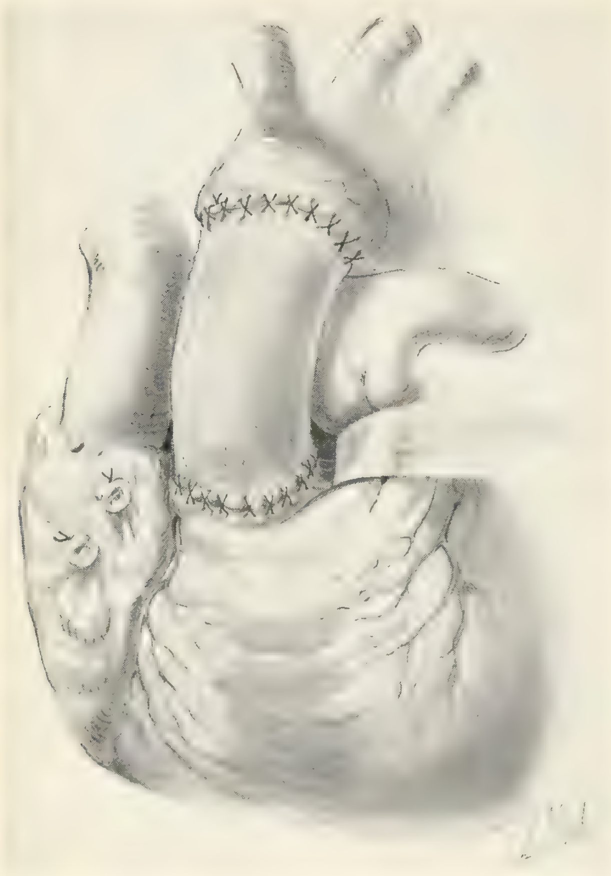
* * *

THE PATIENT WAS operated upon on June 25, 1964, about four weeks following his acute painful episode. A dissecting aneurysm of the aorta was found with the usual marked dilatation of the ascending aorta. There was a circumferential tear of the inner coat with a dissection extending upward toward the innominate artery and downward toward the aortic valve ring. The ascending aorta was resected with coronary perfusion. The right coronary perfusion had to be discontinued because of extravasation of the blood perfused into the ostium. It looked as though the right coronary was somehow involved in the dissection. The ascending aorta was replaced with a preclotted dacron graft. At the completion of the pump run there was some bleeding at the lower suture line. This was re-sutured during two episodes of caval occlusion lasting two minutes each and being four minutes apart.

Postoperatively, the patient was initially quite well. He subsequently, during the first postoperative night and the first postoperative day, had episodes of mental confusion. He had a severe bout of hypoxia with failure of spontaneous respiratory efforts on the second postoperative day. A tracheostomy was done and thick tracheal secretions were removed by suction. A Bennet respirator was then used.

From that time the patient began to improve. He had auricular fibrillation postoperatively with a rate of 130 to 160 but this converted to a regular sinus rhythm on June 29, 1964. There was the appearance of an ischemic pattern on the electrocardiogram involving the posterior ventricular wall. The patient's wound healed well although there was a slight separation of the sternal ends with some false mobility.

The patient was discharged on July 23, 1964, and has done very well since. The blood pressure, which was taken in the recovery room immediately after operation at 110/60, has remained normal since operation. During a postoperative visit on August 12, 1964, it was 140/80. There were no murmurs found at that time and the cardiac rhythm was regular.



Final appearance of the heart after replacement of the ascending aorta with a pre-clotted dacron prothesis.

Discussion

The abrupt appearance of aortic valve regurgitation coincident with a dissecting aneurysm of the intrapericardial aorta may be a dramatic and alarming event as in our second case. Such a case has been operated on by Morris[1] in the acute state within a few hours after its onset with simple resuturing of the aorta required to correct the lesion.

Apparently the first successful surgical repair of dissection of the ascending aorta was done by Mueller[2] in 1958. Subsequently, similar lesions have been operated on by Hufnagel and Conrad,[3] and by Rohman and associates.[4] Hume and Krosnik[5] reported a successful repair of a dissecting aneurysm with aortic insufficiency in pregnancy, the aortic replacement being done three weeks after caesarian section. Spencer and Blake[6] and Dillard and associates[7] have reported operations on this lesion in patients with Marfan's syndrome. The pathological process in Marfan's syndrome with cystic medial necrosis of the aorta pre-disposes such patients to aortic dissection.

* * *

NEITHER OF OUR patients exhibited the classical appearance of Marfan's syndrome. Both of them were of medium height or below and were compact and stocky in build. The histological sections from the initial specimen showed cystic degeneration of the media and also intimal plaques. The other specimen had changes characteristic of atherosclerosis.

The sudden appearance of aortic regurgitation in a patient with a previously normal heart can have multiple causes as discussed in the review by Elliot, Woodburn and Edwards.[8] In our first patient, the absence of pain and the presence of a febrile episode were justifiable reasons for considering his aortic regurgitation to be caused by destruction of a valve cusp by subacute bacterial endocarditis, although his blood cultures were negative. In the second patient, the classical overwhelming pain associated with the onset of the aortic regurgitation is probably typical and characteristic of dissecting aneurysm of the ascending aorta.

Angiograms done with an injection of contrast material into the root of the aorta give the exact diagnosis.

* * *

OPERATIVE CORRECTION requires the use of complete heart-lung bypass with the pump oxygenator. The appearance of the ascending aorta in this condition is quite typical and on incising the aortic wall, the false lumen can be readily identified. The aortic valve itself must be evaluated by the surgeon. Any intrinsic defect of the valve would be a reason for replacement with a prosthesis such as the Starr-Edwards valve. If the valve leaflets are intrinsically sound, then simple replacement of the ascending aorta with a prosthesis with restoration of the valve ring to normal will restore competence. Coronary artery perfusion is carried on during the entire procedure of replacement of the ascending aorta. Naturally, the type of operative approach is applicable to dissecting aneurysms of the intrapericardial aorta where aortic regurgitation is not present.

Some speculation has been made about the possibility of recurrence of the aortic regurgitation in this condition after operation. The first patient, who lived almost a year after the operation and died of an unrelated lesion, had no recurrence of the aortic regurgitation during this period and his cardiovascular status remained excellent. The second patient is well and has returned to work at an automobile plant.

Summary

Two cases are presented of dissecting aneurysm of the intrapericardial portion of the aorta produc-

(Continued on Page 654)

A Preventive Approach To Problems of Child Abuse And Neglect

By RALPH TEN HAVE, M.D.*
ANN ARBOR

The problem of child abuse and neglect is worldwide and very ancient. Infanticide was advocated by a Chinese philosopher in the 19th century to solve the Chinese population problem. Not long after, while sailing near the mouth of the Yellow River, American seamen reported masses of floating babies—mostly baby girls.

An ancient pope in Rome couldn't sleep until he established foundling homes for babies who were being thrown daily into the Tiber River.

In Western Europe, in the 17th century, three-fourths of the babies died in spite of the liquor forced into their stomachs to "harden their systems" and in spite of being bled at the least provocation. In South Korea at the present time poverty stricken women abandon their unwanted baby girls. In Seoul, Korea, the police find an average of five abandoned babies a day.

In the United States we fortunately don't find many babies abandoned in the streets. There surely is no need for any baby to starve, and yet there is a recent report of five infants who were deliberately starved. They were all seven weeks to eight months of age. One infant boy was found dead in his crib by a family friend who had stopped at the home. A bottle of sour milk was in his crib and maggots were crawling around in his soiled diaper. The mother had gone to visit an aunt, leaving the child alone, and did not learn of the child's death until she was called. When she was interrogated by the police she stated that she had noticed "nothing unusual or wrong" with the baby and that she fed him regularly and bathed him daily.

Although she had been advised to bring the child to the well-baby clinic she had never done so because she "just didn't get around to it." Her rent and utility bills were paid by the city welfare department. A check for $70 was sent to her each month for food. Nevertheless, no baby or other food was found in the house.

Further investigation revealed that she had spent a large part of her recent welfare check buying clothes for herself. This baby's mother was indicted for second-degree murder. After a period of observation in a state mental hospital and prior to the trial, she was found legally sane. At the time of her trial she was six months pregnant out of wedlock.

The coroner-pathologist in these five cases was very upset. He stated, "The challenge in the case of the starved child is one of prevention. It devolves upon the welfare agencies to search out instances of child neglect long before the situation has deteriorated to an irreparable state. Merely requesting that the mother bring the child to a clinic or hospital is obviously not adequate in some instances. Persistent follow-up and stubborn insistence are required if more such tragedies are to be averted. It is not sufficient to arrest, condemn and punish mothers after the child is dead."[1]

* * *

THE MORE striking picture of child abuse is the battered child. Most people including public health doctors, nurses, and social workers, find this very difficult to understand or accept. However, we can't help but be aware that this is a growing problem in our society.

In 1953 Doctor Silverman, a radiologist, described multiple bone injuries as "the most common disease of infancy."[2] In various quarters efforts were made to pin the entity to organic disease, but these hypotheses proved to be incorrect. Although the bone injuries may occur in well-nourished, clean children, more often the child's general health is below par, and he shows evidence of neglect, including poor skin hygiene, multiple soft tissue injuries and malnutrition. And there is a marked discrepancy between the clinical findings and the historical data as supplied by the parents.

Most of us are interested to know what kind of parents abuse their child. Here is a brief case history.

"A three-month-old infant with enlargement of the head, convulsions, and spells of unconsciousness was brought to a hospital. Examination revealed bilateral subdural hematomas which were later operated on with great improvement. The mother, aged 21, a high school graduate, was very warm, friendly, and gave the appearance of having endeavored to be a good mother. However, it was

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*Maternal and Child Health Unit, University of Michigan School of Public Health, Ann Arbor.

This article raises the question of preventing new cases of child abuse and neglect through family planning. By helping to delay pregnancy and child birth for couples who have shown that they are unwilling and ill-prepared psychologically for the responsibilities of parenthood it may be possible for the physician to help the parents and exisiting children more with effective new birth control methods than with counseling alone.

noted by both nurses and physician that she did not react appropriately or remain as upset about the baby's appearance as did her husband. From interviews with the father and later the mother it became apparent that she had occasionally shown very impulsive, angry behavior, sometimes acting rather strangely and doing bizarre things which she could not explain or remember. This was their first child and had resulted from an unwanted pregnancy which had occurred almost immediately after marriage and before the parents were ready for it. Early in pregnancy the mother had made statements about giving the baby away, but by the time of delivery she was apparently delighted with the baby and seemed to be quite fond of it. After many interviews it became apparent that the mother had identified with her own mother who had also been unhappy with her first pregnancy and had frequently beaten her children. Despite strong conscious wishes to be a kind, good mother, she evidently was repeating the behavior of her own mother toward herself. An admission of guilt was never obtained."[3]

* * *

MR. VINCENT De Francis, Director, Children's Division of The American Humane Association, gives the following underlying motivations for child abuse. An emotional explosion was responsible for the abuse in the vast majority of cases where the father was responsible. It was usually an instantaneous reaction to a particularly irritating occurrence or an attempt at discipline which got out of control.

Mothers, however, seemed influenced by deeper psychological pressures and showed more disturbed, imbalanced and irrational thinking. Deep depression was the basis for horrible phantasies such as "returning the child to God" or saving the child from pain through mercy killing. Premature discharge from a mental hospital has resulted in parents committing serious acts of abuse on their children.[4]

The American Humane Society is a leader and pioneer in the child protective movement. Apparently the first real action towards child protection arose from the Society for the Prevention of Cruelty to Animals. They were first appealed to on the basis that a child was an animal and deserved protection too. However, it hasn't been until recent years that child protective services were even offered west of Chicago. Recently the American Humane Society in Denver had their hands full as they tried to influence 18 state legislatures in which legislation was introduced on this subject in the past year. Mr. De Francis claims that the legislation in some cases was hastily conceived.

> *Indiana, Minnesota, and Wisconsin, among others, defined child abuse as a crime and were concerned only with punishment of the offender. Minnesota, Ohio, and Wisconsin, among others, made laws requiring mandatory reporting of child abuse.*

But, De Francis asks, "Once the child is identified, what then?" He again asks, "Why in the criminal code?"[5]

* * *

THERE CAN BE little doubt that severe physical abuse of a child in some way implies a lack of or distortion of reality. Although many of these parents are not continuously or overtly schizophrenic, many of these individuals who have episodic outbursts or loss of control, loss of reason and loss of judgment, represent a type of schizophrenia. Their denial, projection and tendency toward being resistive are all characteristic of this schizoid type of personality. These people attempt to handle the overwhelming anxiety they feel within themselves by externalizing this destructive force and attacking or killing. They fear close, intensive relationships.[6]

It is not surprising then to find that counseling carried on in social agencies has been far from successful or rewarding. Many of the parents are themselves so psychologically damaged that they are beyond the reach of our present therapeutic measures.

At present the only solution in many cases is to remove the child from the home by court order. It is unfortunate that the court then must thrust the child into institutional or foster care.

Those who work in child protective service can do casework at the home of the neglected child most effectively if there is early detection of a problem. There is frequently a serious gap between the time when mild neglect is first noted, perhaps by teachers or public health nurses, and the time when it becomes severe. Getting the child identified before it is physically or emotionally ruined has been difficult.

* * *

OBVIOUSLY THE role of the physician and nurse in early detection is of crucial importance. When a family is referred early to a protective service rather than to the police, the caseworker will tend to use the aggressive approach with some use of authority, which offers protection not only for the child but also for the parents against their own impulses which threaten to overwhelm them.

This is a serious problem when one considers that in a certain hospital the re-admission rate for children previously injured from abuse was 50 per cent and the mortality rate was 10 per cent for children after discharge home following treatment for inflicted injuries.[7]

It would certainly seem reasonable that everything possible should be done to prevent the first episode of child abuse through the early use of child protective services.

* * *

WHEN ONE CONSIDERS the tragic seriousness of the problem there really should be more ways to prevent child abuse in the first place.

This is definitely a problem that needs primary prevention. We all know it is extremely difficult to change the parents themselves. We know that the ability of individuals to withstand stress varies considerably. In the schizophrenic this is their essential weakness. Unfortunately there is increasing stress on young people who are marrying earlier while the educational and employment prerequisites for optimum social adjustment require more and more time. We find that schizophrenic males are marrying four times as often and females twice as often as they did twenty years ago.[8] It has been observed that the parents involved in child abuse and neglect are often unusually ill-prepared for the stress of pregnancy and anticipated birth of the infant.[3,7] When one considers the environmental hardships and the poor mental or physical health of the parents, the stage seems set for another tragedy, if each pregnancy follows closely on another pregnancy.

Physicians have reported that child abuse and neglect is often related to the fact that the parent or parents didn't want the child.[3,7] *Social workers in the protective service field generally ignore this fact. It is surprising that the question of family size, excess fertility, or the simple fact of an unplanned pregnancy is not raised publicly except for a few voices in the planned parenthood movement and in the maternal and child health field, as well.*

In some of the high grade mental defectives we can also find family histories of child neglect. In desperation, perhaps due to the failure of those in maternal and child health to take their responsibility in offering birth control services, state legislatures and even the United States Supreme Court decided in favor of sterilization of mental defectives.

It is strange when one considers the relatively extreme action of such official bodies, that public health and especially physicians and nurses in maternal and child health haven't offered simple voluntary methods of spacing children to those too poor in mind or purse to go to a drug store or private physician.

* * *

IT IS INTERESTING that voluntary sterilization is increasingly requested at all social levels. Elective hysterectomy is a nice, socially acceptable means of sterilization and provides stimulating conversation at many bridge parties and country clubs. It is unfortunate that the socially disadvantaged who desperately want to limit their family size and literally long to be sterilized can't get it done. The surgeon's operative fee is frequently excessive for these families, perhaps because of his reluctance to perform sterilizations.

Social welfare departments can help by having reasonable, consistent policies of referral and payment for voluntary sterilization and birth control services for needy families.

The reluctance of health departments, private physicians, and hospitals to perform sterilizations is peculiarly widespread. The fact is that there are only five states, Connecticut, Kansas, North Carolina, Utah, and Virginia, which have specific regulations regarding voluntary sterilization.[9] *There is no record of any physician losing a suit when the proper consent form had been signed by*

> *the patient and there has been no malpractice.*[10]

The major disadvantage of the method is its irreversibility. This, however, is advantageous for a mentally sub-normal young couple who may request the operation because they wish to enjoy the satisfactions of a normal life without assuming more of the responsibilities than they are able to handle. One can almost assume in such cases that there is a possibility of having accomplished primary prevention of child neglect if not child abuse.

It is certainly our professional responsibility to provide guidance and instruction in family planning to all defective families; family planning should be considered teachable and a privilege, not a penalty, since even defective couples will not choose to burden themselves with offspring beyond their potential to support.

* * *

NO HEALTH DEPARTMENT'S program is adequate unless it offers family planning as an essential part of maternal and child health services. There are many other reasons for saying this, such as the following: 1. In Western Germany induced abortion which is frequently a woman's answer to her own population problem, results in more infection and maternal mortality than all infectious and contagious diseases combined. In Michigan, infection—mostly from induced abortion—is the leading cause of maternal death. 2. The probability of a mother having a mongoloid infant after age 40 is 50 times greater than if she had a child in her twenties. 3. Maternal mortality is four times greater after age 35 and six times greater after age 40 than in the *early* twenties.[11] 4. A mother who has six or more children has three times as much primary uterine inertia, five times the possibility of hemorrhage at delivery and twice as many still births as one who has less than six.[12] One could go on and on with reasons why mothers and fathers should plan conceptions and limit family size.

J. W. R. Norton, M.D., immediate past President of the American Public Health Association and long-time Director of the North Carolina State Health Department, began family planning services in local health departments over 25 years ago. In a recent LOOK magazine article about birth control services in Mecklenburg County, North Carolina, Maurice Kamp, M.D., clearly expressed his thoughts on the religious question when he said, "I don't think it is emphasized enough that birth control is not a religious question. No group is opposed to family planning. If a clinic makes all methods available, it is certainly meeting the needs of people within the boundary of any belief."[13]

Recently, there has been an increasing amount of openly expressed dissatisfaction by many Catholic laity and clergy. This dissatisfaction centers around the unreliability of the rhythm method and the marital tensions that arise from its use.

Protestant public health workers should not use the convenient excuse of "Catholic opposition" and admit that their own lethargy and anxiety prevents them from doing their duty.

> *The time is right for individual and departmental decisions to include birth control services as part of public health professional duty to mothers and children. When it has been decided to include family planning services then it should always be offered to parents even when they want more children and before the need becomes self-evident. All parents should know the reasons for spacing births and limiting family size. They should know how they can effectively plan their family within their beliefs and desires.*

A major problem for most parents is that the vaginal methods of contraception are messy, inconvenient and often used irregularly and ineffectively. A recent unpublished study in Detroit shows that 40 per cent of the socially advantaged

---

Child abuse certainly is nothing new and has probably always been with us. Here is a sketch by Artist Michael Armstrong and was used in the booklet "Man, Medicine and Work" by the U. S. Government to tie in with historic comments about the early 1800's in England.

couples' last babies were unplanned. Sixty to 70 per cent of the socially disadvantaged couples' last babies were unplanned. The average mother in the United States has completed her desired family size by age of 28.[14] That, of course, leaves approximately 17 years of precarious effort with the traditional methods of birth control for the average mother.

* * *

THERE ARE TWO newer methods of birth control which are superior to the traditional methods and avoid the irreversibility and the operative procedure required by sterilization.

The Maternal and Child Health Unit of the University of Michigan School of Public Health is testing them in two neighborhood clinics located in churches in Detroit. Though all methods of family planning, including rhythm, foam, jelly, diaphragm, condom, and referral for sterilization are offered, most of the women choose either the oral contraceptive or the intra-uterine method.

The oral contraceptive now has a clinic price of $1.10 per month for the 2 mg tablet and is safe and 100 per cent effective if taken as instructed. It has the advantage of being unrelated to the sexual act and of giving very complete protection. However, the woman must take a pill by mouth 20 days a month which requires considerable motivation. The intra-uterine method, which is now being used by about 10,000 women in the United States, is much simpler, cheaper and requires only the initial motivation to come to the clinic for insertion. At the clinic the physician inserts a small radio-opaque plastic coil, loop, or bow into the uterine cavity. The insertion is usually painless and requires no dilatation of the cervix, since the insertor is of very small diameter. The device can stay in place for several years or be removed painlessly in a few seconds by a doctor any time the woman desires another baby.

> *The intra-uterine device has been used in some parts of the world for over 30 years and there is no evidence that it is carcinogenic, causes infection, or causes any serious complications in mother or child.*[15] *It is, however, not yet a perfect method of contraception, since it is possible to expel the device, and many of the women experience longer and heavier menstrual periods while using the device. However, the device is being intensively studied, and there should be improvements which we hope will eliminate these two problems.*

These new developments in methods and others now being developed, will make it possible for health departments to do something besides fret when they see parents who are usually ill-prepared for pregnancy and who really want to receive family planning service which they can afford.

* * *

WHILE SO FAR this has evidently not been stressed on their multi-discipline approach, it would appear that the Child Protective Service in your commuunity should be glad to include the health department's family planning service in its approach to families in need of protective service. The Child Protective Service has already enthusiastically acknowledged the leadership of the medical profession, which brought the battered child into national recognition as a community problem of high priority order. Now is the time when the Child Protective Service needs the support and encouragement of the health department nurses, physicians, and social workers to aid its program of some primary prevention in families where there have been abused and neglected children.

However, it has been our experience that public health physicians, nurses and social workers require additional information about the reasons for family planning, the newer methods of contraception, and the proper approach to families before they feel comfortable and adequate to help any other agencies with problems in this area.

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The Treatment Of Migraine

By JOHN R. GRAHAM, M.D.
OF MASSACHUSETTS

First, I should like to present to you my theory about the nature of migraine in brief, since, whether true or not, it lends itself to a workable concept of treatment. My theory is that migraine is an inherited disorder involving the cranial neurovasculature which renders it incapable of making proper adjustments to a variety of stimuli.

Figure 1 above shows a diagram of the normal subject; stimuli from the external environment or from the internal physiologic or psychologic environment call for a response in the direction of vasoconstriction in the cranial neurovasculature. This takes place normally and is followed by a normal counter response of vasodilation. The adjustment passes off as a physiologic event without significant symptoms.

In the migraine subject, however, (Figure 2 above) when the same stimuli are applied, due to some hereditary aberration, an excessive vasoconstrictive response occurs, leading to the malfunction observed at the beginning of an attack, and is followed by excessive dilation of the blood vessels and local development of edema and a "sterile inflammation" which produces headache. General bodily defenses finally bring this counter response to a close and a period of temporary immunity may follow.

Thus, the migraine patient may be compared to a highly explosive fire-cracker, which can be set off easily by any one of these naughty boys (Figure 3 above), the stimuli from the external or physiologic or psychologic environment, to produce the migraine "explosion" or attack.

Treatment divides itself into three areas: 1. removal of stimuli, 2. increasing the resistance of the "firecracker," and 3. dampening the "explosion." The area of dealing with the stimuli is perhaps the most important, but often receives the least attention because it is time-consuming. Until we find some very specific, harmless and inexpensive

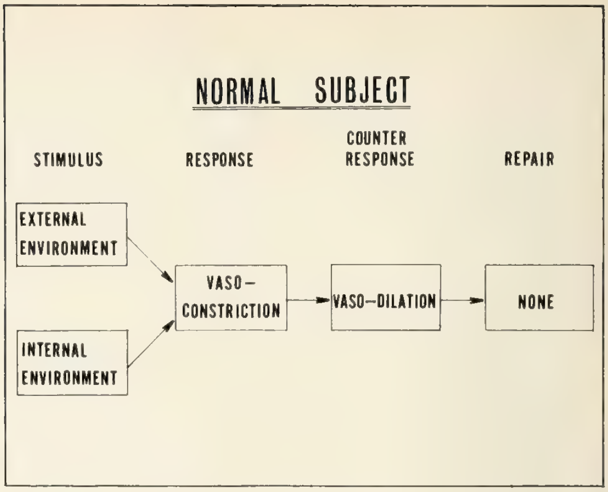
NORMAL SUBJECT
STIMULUS
RESPONSE
COUNTER RESPONSE
REPAIR
EXTERNAL ENVIRONMENT
INTERNAL ENVIRONMENT
VASO-CONSTRICTION
VASO-DILATION
NONE

Figure 1. Graphic concept of neurovascular reaction in normal subject.

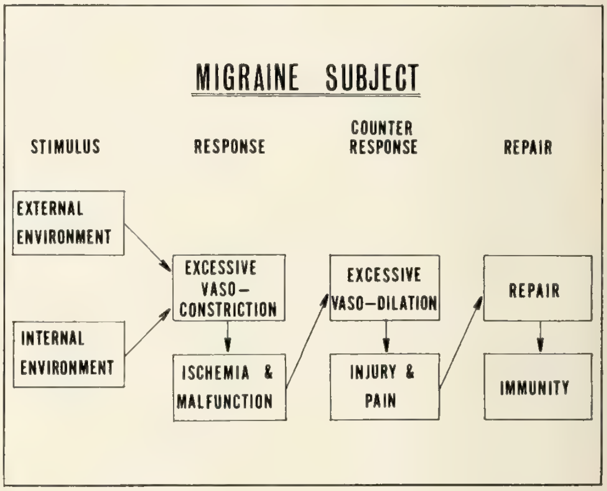
MIGRAINE SUBJECT
STIMULUS
RESPONSE
COUNTER RESPONSE
REPAIR
EXTERNAL ENVIRONMENT
INTERNAL ENVIRONMENT
EXCESSIVE VASO-CONSTRICTION
ISCHEMIA & MALFUNCTION
EXCESSIVE VASO-DILATION
INJURY & PAIN
REPAIR
IMMUNITY

Figure 2. Graphic concept of neurovascular reaction in migraine subject.

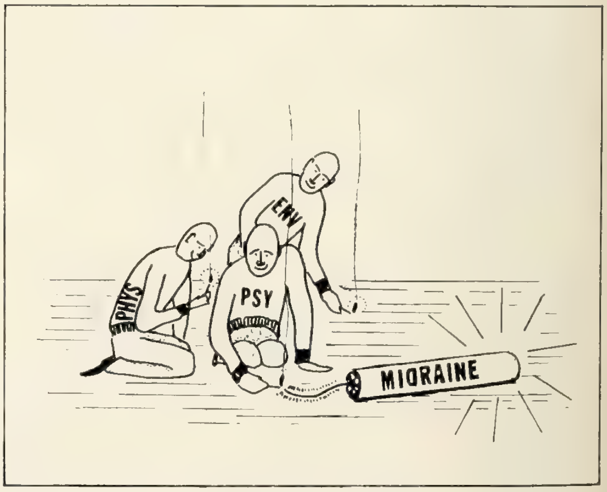
ENV
PSY
PHYS
MIGRAINE

Figure 3. The Migraine firecracker.

The Faulkner Hospital, Jamaica Plain, Mass.

TABLE I. COMMON MIGRAINE STIMULI FROM THE EXTERNAL ENVIRONMENT

External Environment	
Strong light, noise, smells	Chemical agents
Barometric changes	Alcohol, Nitrites,
Temperature changes	Histamine, Amphetamines,
Anoxia—Altitude, CO	Reserpine, Nicotine

TABLE II. COMMON MIGRAINE STIMULI FROM THE INTERNAL ENVIRONMENT

Internal Environment	
Hypoglycemia	Fever
Anoxia	Allergic reactions
Syncope	Anxiety
Physical activity	Fear
Loss of sleep	Rage
Menstrual changes	Prolonged mental strain
Adrenal hypofunction	

pharmaceutical prevention of migraine, a bullet that hits the congenital aberration in migraine squarely, we need to continue to spend that time with the patient which will enable us to learn what stimuli are active in his case and to teach him to avoid them or alter his pattern of living and feeling so that they beset him less.

Some common stimuli from the external environment are listed in Table I above. One alone may not produce the migraine attack when combinations will. Thus, alcohol on a hot day, or the smell of paint plus the noise of construction may league together to push the sensitive subject into an attack.

In the same way, a number of common stimuli (see Table II above) from the physical and emotional environment may, singly, or in pairs, operate to produce headache. A day shopping, without lunch, at the time of the menstrual cycle is a good example; or loss of sleep and excessive nicotine and prolonged mental strain make an effective combination. Time spent with the patient on these details is still the most important ingredient of migraine therapy.

* * *

TURNING NOW to the task of toughening up the firecracker, or the patient himself, we may divide our approach into three categories. The first—general, nonspecific measures, which help improve the daily health and resistance of any patient. Thus, if the patient has a thyroid deficiency, or anemia, or sinus infection or allergies, or an error of refraction, correction of these difficulties will help him to resist the migraine stimuli.

Then, there is a group of disturbances which come closer to the heart of migraine and which may bring benefit when successfully combatted, although still not specific. Reduction of fluid accumulation and emotional tension at the time of the menses, or the use of prophylactic ergot drugs for a short time may be helpful in catamenia-bound migraine. Occasionally, the creation of anovulatory cycles by the use of estrogen-progesterone combinations may prove helpful. Testosterone, although sometimes effective, is fraught with unpleasant side effects. The creation of an artificial menopause by radiation or surgery, is more apt to promote headache than to relieve it.

The development of mild essential hypertension in middle life is more common in migraine patients than in normals. When this happens, headaches which were previously infrequent may begin to occur more often, and even daily, and gain the new name of "hypertensive headache." Considerable improvement may be achieved by using small doses of antihypertensive medication, such as a combination of Chlorthiazid with .1 to .25 mgm of reserpine, and raising the head of the bed at night, and restricting salt moderately.

* * *

IN SOME MIGRAINE patients, especially those with Classic Migraine and in children, the brain wave may show mild cortical irritability and dysrhythmia. Phenobarbital, dilantin, mysoline and other anticonvulsant drugs are worth a trial in these patients. Similarly, in a non-specific way, drugs of the tranquilizer variety, such as Miltown, Librium, Valium and others may prove useful to the migraine sufferer who is constantly anxious and upset. It is more common in my experience to find the migraine patient tired and depressed, and to be benefited by the mood-improving, energizing drugs of the mono-amine oxidase inhibitor type such as Marplan.

In the past five years, a new and more specific method of toughening the migraine firecracker has appeared in the form of methysergide or Sansert. This drug, which is chemically related to the ergot family, has proved to be the most effective agent developed so far for preventing or suppressing migraine.

Sansert was first introduced into the therapy of migraine by Sicuteri in Italy because of its ability to antagonize serotonin which was thought to play a role in the pathogenesis of migraine. Since then, it has been found that Sansert is an antiinflammatory agent, an anti-sludging agent, a vasoconstrictor, and that it has some effect on dampening vasomotor responses mediated through the hypothalamus. Which of these actions is the effective one in migraine is as yet undetermined. Its usefulness is almost entirely in the area of prevention of attacks rather than treatment of an attack once it has begun. It has no place in the therapy of headache other than those types which have a large vascular

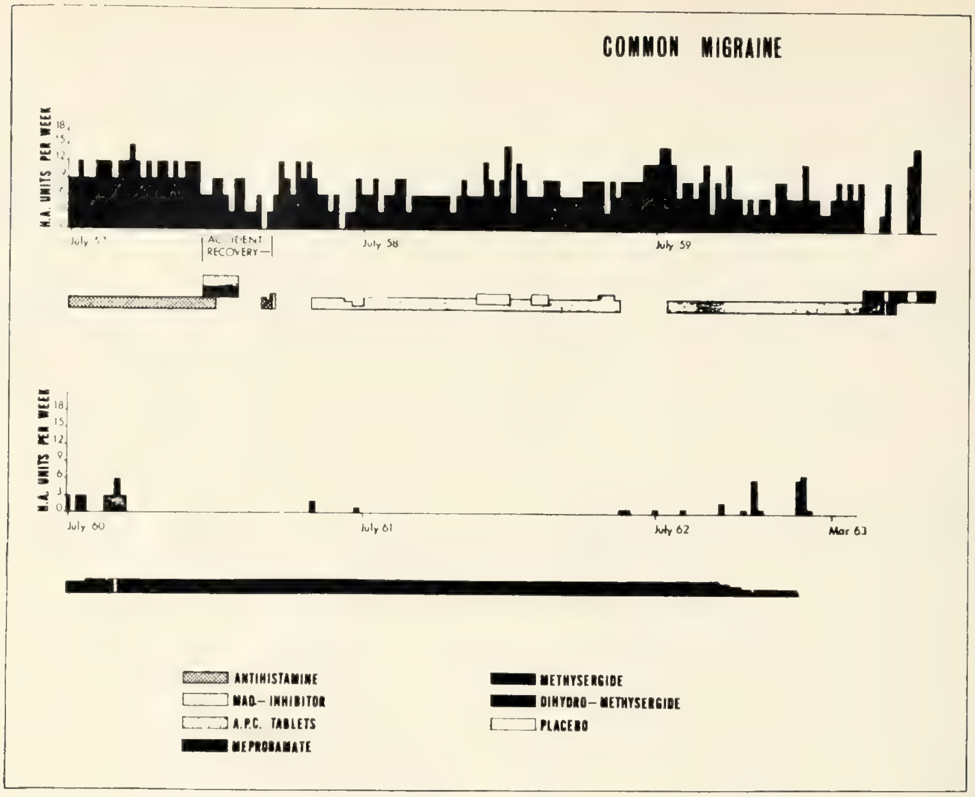

Figure 4. Headache record of migraine patient before and during methysergide therapy.

component in their mechanism.

In Classic and Common Migraine and Cluster Headache of the type described by Horton as "Histaminic Cephalalgia," and in the migrainous headaches associated with mild hypertension, Sansert has a batting average of producing worthwhile results in about 70 per cent of patients. To some subjects, severely afflicted, it has proved to offer a new lease on living without pain. An example of such a patient is shown in Figure 4, below.

* * *

FOR 20 YEARS, this sufferer from frequent migraines had kept accurate records of his attacks and tried a score of different remedies. The graph shows how his headaches were almost completely eliminated for two and a half years while he took Sansert. But rare indeed is the effective drug which has all good points and no bad points. Sansert has side effects which keep about 15 per cent to 20 per cent of patients from taking it at all and which, in those who do take it, call for close observation and periodic follow-up by the physician. These considerations, the expense involved, and the nuisance of taking pills two or three times daily over long periods of time would make it appear that Sansert should be reserved for those patients whose headaches, either by virtue of their severity or frequency, are seriously affecting their social or economic welfare.

The most common side effects from Sansert are gastrointestinal-nausea, abdominal pain and diarrhea. Usually these appear at once, but, in occasional patients, they may begin after weeks or months of therapy. If a patient taking Sansert develops "G.I." complaints, it is well to stop the drug before putting the patient through innumerable tests and x-rays. Symptoms due to the drug disappear within a few days. In some patients, the administration of a digestive enzyme drug called Festal with each dose of Sansert is effective in neutralizing the intestinal disorders.

Insomnia, drowsiness and peculiar unworldly sensations affect a few patients, but are rarely severe enough to discontinue therapy.

* * *

OUR GREATEST concern has arisen from the fact that, in some individuals, Sansert, even in small amounts, can cause major constriction of major arteries. We have seen examples of intermittent claudication of arms and legs, the Le Riche Syndrome, and accentuation and production of coronary symptoms. These point up the necessity of checking the patients on Sansert three or four times a year, and examining their heart and vessels by palpation and stethoscope. Bruits over major vessels, such as the carotid, brachial, aorta and femorals, may be the first sign of significant vasoconstriction. The development of intracardiac murmurs has also been reported in rare instances and demands cessation of therapy. The presence of valvular heart damage or coronary disease contraindicates the use of the drug.

An increased appetite and resulting weight gain have been side effects which trouble the ladies, particularly, and urge us to caution them about their calories.

Peripheral edema and fluid retention are other troublesome complications, at times requiring salt restriction, or even diuretic therapy.

* * *

THERE IS A suggestion that Sansert may affect the venous side of the circulation as well as the arterial. For this reason, it should probably not be given to patients who for some reason may be prone to thrombophlebitis, such as those in the postoperative period or those suffering from infection or cellulitis in an extremity or those who have a history of recurring phlebitis.

A few patients have complained that their hair fell out more easily while taking Sansert. It has been hard to relate this definitely to the drug. Most of the patients have continued to take it and the tendency has ceased.

A flushed appearance of the skin of the head and neck has occurred in some patients, but I know of only one instance in which a real skin rash could be traced to this drug.

In the past two years, 27 patients, out of the approximately 400,000 who have taken Sansert, have turned up with vague abdominal pains, flank pain, costovertebral pain and, eventually, some degree of urinary obstruction. Fourteen of them have been operated upon and proved to have retroperitoneal fibrosis. The others have presented every evidence of this disease by x-ray and cystoscopy and retrograde pyelography, but the symptoms and findings have regressed upon withdrawal of the drug. Most of these patients had taken many other drugs. Most of them were very severe migraine sufferers. Whether the development of retroperitoneal fibrosis in these patients represents its natural incidence or is related to the disease migraine as one of its manifestations or is in some peculiar way a side effect of Sansert is currently a matter of intense investigation. Suffice it to say, for the time being, that an intravenous pyelogram should be included in the workup of patients taking Sansert who present vague abdominal or genito-urinary symptoms.

Three examples of pleuro-pulmonary fibrosis developing in the course of methysergide therapy have also been observed. Although a causal relation is not yet clear, it may be wise to avoid using this agent when chronic pulmonary disease is present.

From the foregoing you will have concluded that Sansert is contraindicated in patients known or suspected to have vascular disease, whether venous or arterial, peripheral, cerebral, coronary or renal. Valvular heart disease and chronic pulmonary conditions also make its use undesirable.

Pregnant patients and those with fertility problems should not take it because it has mild oxytoxic properties. Liver and renal disease and septic states conclude the list of contraindications.

* * *

LEST THIS array of side effects dismay you, let me emphasize again that for those suffering from frequent migraines this drug is a godsend. As is the case with many other important drugs such as digitalis, the antibiotics, and narcotics, it is the physician's task to select those patients for whom their use is justified and to understand the risks and techniques of using them as well as the benefits involved.

Sansert comes in pills of 2 mgm each. It is usually wise to start treatment with one pill at bedtime for a few days or a week. The bedtime dose is the most important dose since most migraines are brewed during sleep and the aim is to get ahead of the headache with the prophylactic agent. A report by phone from the patient will alert you to side effects or the necessity of adding another pill at breakfast and later maybe another pill at lunch or supper. Four pills, or 8 mgm, per day should be the top dose. By such a gradual increment over two or three weeks, side effects may be noted and minimized and the smallest effective dose may be determined.

* * *

MOST PATIENTS who need Sansert need to take it daily for months or even years. Occasional patients, whose headaches are known to occur at certain particular times, like weekends or the menstrual period, may get by with taking it only at those times. Sudden cessation of therapy is apt to

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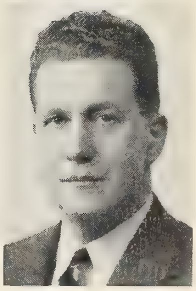

be complicated by severe flare-up of headache.

Gradual dose reduction over weeks or even months should be tried from time to time preferably under ideal circumstances like vacation, to see if the patient can get along with less drug or, in some cases, none at all. During Sansert therapy if headaches break through, ergotamine may still be used but smaller doses—perhaps half the usual amount—are usually effective and are advised to avoid synergistic ergot-like side effects. Other medicines, so far as I know, may all be taken with Sansert. In the light of the appearance of possible complications of Sansert therapy such as retroperitoneal fibrosis and cardiac murmurs, recent thinking has suggested the advisability of interrupting Sansert therapy for at least two months out of every year.

Now for a few remarks about controlling the "explosion." Whenever the migraine patient has an attack it means that somehow, physiologically or psychologically, he has been exceeding his speed limit and the headache is his "ticket." If you "fix" this "ticket" for him every time, too easily, he will never learn to pay attention to the speed laws. If by your drugs you can stop the pain of his headache, try to teach him, in addition, that he must also achieve the rest for which his headache shows the need. Though ergotamine may have stopped his attack, insist that he get home early that day or break in some way the overcrowded schedule or state of emotional tension that precipitated the attack.

* * *

MIGRAINE SUFFERERS who come to the doctor for help usually have tried all the ordinary analgesics without relief. For them the backbone of therapy for the attack is usually ergotamine tartrate. This may be administered by five different routes. The more convenient but less effective routes are: 1. the oral ingestion of tablets such as Cafergot, Cafergot P.B., Wigraine and Migral, or 2. the sublingual absorption of Ergomar, or 3. the inhalation of ergotamine as a mist from the medihaler-ergotamine. More reliable in their efficacy are rectal preparations such as Cafergot P.B. Suppositories, Wigraine Suppositories or Rectalad-ergotamine. Most reliable of all is the subcutaneous or intramuscular injection of Gynergen or Dihydroergotamine. One should not say that ergotamine has failed in a case of suspected migraine until the parenteral injection has been tried early in an attack. The method of use in a given patient must be tailored to fit the individual, his skills, his tastes, his work and the nature and severity of his headaches. The fact that ergotamine is much more effective when given early in the attack places considerable weight on "convenience" of administration as well as "efficaciousness" when you choose the particular route and product for a given individual.

Nausea is frequently a part of the migraine attack or the result of drugs used for its relief. It is frequently helpful to give the patient an anti-emetic before administering one of the ergot products. Oral, rectal or parenteral use of Thorazine or Compazine or Tigan or Torecan often is a useful supplement.

* * *

SOME PATIENTS cannot tolerate ergotamine tartrate but can manage dihydroergotamine. Others can take neither and for a few of these Octin Hydrochloride by injection may be effective. Some may have to have narcotics for the attack. In such instances these should be given by a physician who is not a member of the family. This is particularly true in the case of physician's wives. I have seen three of my colleagues' wives become addicts when their husbands, usually in order to save bothering their friends, took on the job of managing the headaches of their spouses.

Faulkner Hospital
Boston, Massachusetts 02130

Continued:
Intrapericardial Aorta

ing aortic valve regurgitation. Both patients were operated upon with resection and replacement of the intrapericardial aorta with a woven dacron prosthesis.

This procedure corrected the aortic valve regurgitation in each instance without replacement with an artificial valve.

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A CASE REPORT:

Procaine Amide Hydrochloride (Pronestyl) Induced Agranulocytosis

BY
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BOTH OF DETROIT

The usefulness of procaine amide hydrochloride (Pronestyl) in the therapy of cardiac arrhythmias has been well documented during the past decade. The fact that this drug is capable of producing agranulocytosis has been reported on at least four previous occasions.[1-4] The paucity of reports concerning this complication of procaine amide therapy in view of its widespread clinical use, probably reflects the relative safety of the drug.

The severity of this complication if undiagnosed, and the belief that the greatest aid in making the diagnosis is the awareness of this complication, prompts us to report the following case.

* * *

THE PATIENT, a 71-year-old white male, was admitted to the Orthopedic Service at Dearborn Veterans Administration Hospital on July 18, 1961, with an intertrochanteric fracture of the right femur. Open reduction and internal fixation with a three and three-fourths inch Jewett nail plate was performed on July 20. Hypotension, occurring at the time of surgery, responded to vasopressors and one unit of blood. An electrocardiogram in the recovery room revealed an acute anterior myocardial infarction, and on July 21, the patient was transferred to the Cardiology Service.

PHYSICAL EXAMINATION

July 21, 1961: Temperature 98.4°F, blood pressure 120/80, pulse 92, respiration 20. Funduscopic examination revealed grade 1 retinopathy, mouth was edentulous, tongue and throat were normal, lungs were clear to auscultation and percussion, and an apical heart rate of 92 per minute was regular with frequent premature beats. An incisional wound was present on the lateral aspect of the right thigh, and a slight residual left hemiparesis remained following a cerebral thrombosis suffered three years previously.

LABORATORY DATA

The total white blood cell count on admission was 12, 300/mm^3 with 82 per cent granulocytes; hemoglobin 12 gm/100 ml; hematocrit 37 per cent; blood urea nitrogen 18 mg/100 ml; fasting blood sugar 96 mg/100 ml; serum glutamic oxalacetic transaminase 79 units; and serology (Venereal Disease Research Laboratory) negative. Urinalysis revealed 40-50 WBC/high-power field in the urinary sediment, and urine culture grew out Escherichia coli and Bacillus proteus. Chest x-ray was within normal limits. Electrocardiogram revealed a normal sinus rhythm with frequent ventricular premature beats and an acute anterior myocardial infarction.

HOSPITAL COURSE

On July 21, procaine amide hydrochloride 0.25 gm orally four times daily was started because of frequent ventricular premature beats. Phenobarbital 30 mg four times daily also was given for sedation. Convalescence was normal until October 4, when, while on the above medication as well as phenoxymethyl penicillin (V-Cillin) 1,200,000 units daily for a small wound infection of the operated right hip, a temperature of 101.6°F was noted. The apical rate was 104 and regular. The patient appeared somewhat lethargic but the remainder of the physical examination was unchanged. On October 6, the temperature rose to

ABSTRACT

The efficacy of procaine amide hydrochloride (Pronestyl) in the treatment of certain cardiac arrhythmias has been well established. An uncommon but important complication of this drug is the development of agranulocytosis. Recovery from this complication depends upon its prompt recognition so that immediate withdrawal of the drug can be effected and proper therapy instituted.

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TABLE I

Date	Total WBC /mm³	% Lymphocytes	% Monocytes	% Segmented	% Non-segmented cells	% Myelocytes	% Eosinophils	% Basophils
7-18-61	12,300	14	4	78	3	0	1	0
8- 8-61	8,450	22	7	71	0	0	0	0
9-26-61	5,100	42	5	53	0	0	0	0
10- 6-61	1,200	98	2	0	0	0	0	0
10- 7-61	1,600	91	8	1	0	0	0	0
10- 8-61	1,500	90	4	6	0	0	0	0
10- 9-61	1,000	72	12	16	0	0	0	0
10-10-61	6,750	22	4	47	21	6	0	0
10-11-61	15,400	26	1	71	2	0	0	0
10-13-61	23,100	5	16	79	0	0	0	0
10-14-61	28,900	7	4	86	1	2	0	0
10-15-61	25,600	10	3	82	5	0	0	0
10-16-61	18,500	13	5	81	0	0	0	1
10-17-61	18,600	11	2	76	11	0	0	0
10-18-61	25,050	5	1	91	1	2	0	0
10-19-61	14,900	16	2	81	0	0	0	1
10-20-61	12,000	19	5	76	0	0	0	0
10-21-61	12,600	13	6	80	1	0	0	0
10-23-61	9,600	21	5	74	0	0	0	0

105.6°F, and the patient became disoriented, complaining of dysphagia and sore throat. The pulse remained regular at 120 per minute, respirations were of the Cheyne-Stokes type, slight dysarthria was present, and the pharyngeal and buccal mucosa were erythematous but without ulceration or exudate. A few dry rales were present bilaterally. Chest x-ray was normal. Total white blood cell count was 1,200/mm³ with 98 per cent lymphocytes and 2 per cent monocytes. The hemoglobin was 12.6 gm/100 ml and the platelets were reported as being adequate.

Procaine amide hydrochloride and phenobarbital were discontinued and, in view of the patient's lethargy and dysphagia, orally administered phenoxymethyl penicillin was replaced by the intramuscular injection of crystalline penicillin G potassium 1 million units every four hours, as well as streptomycin 0.5 gm intramuscularly every 12 hours.

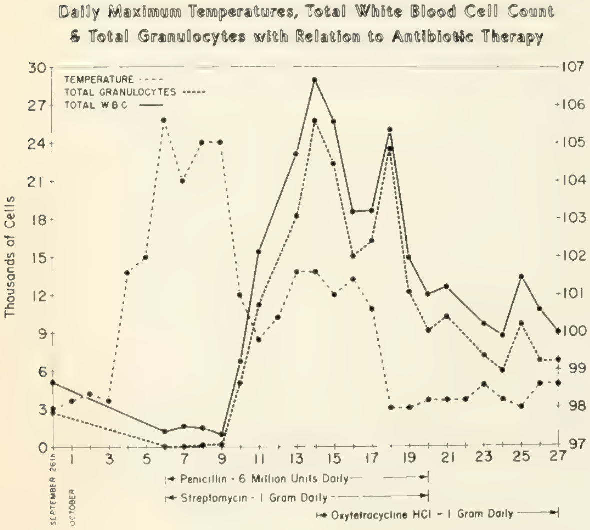

Figure 1.

The chart (Figure 1) shows the daily maximum temperature record with relation to the total granulocytes, as well as the antibiotics used. The accompanying table (Table I) is a summary of the total white blood cell counts, including differentials, obtained throughout hospitalization. The patient's condition remained critical during the following three days with continuation of disorientation, daily temperature elevation of 105°F, and frequent ventricular beats.

On October 9, digitalization was undertaken because of increasing signs of congestive heart failure. The following day the temperature was 101°F, and total white blood cell count was 6,750/mm³ with segmented polymorphonuclear cells 47 per cent, stab cells 21 per cent, and myelocytes 6 per cent. White exudate and shallow ulcerations of the pharyngeal and buccal mucosa were now present. X-ray examination of the chest on October 14 showed evidence of left upper lobe pneumonitis, and as the temperature and white blood cell count continued to rise, oxytetracycline hydrochloride (Terramycin) 1 gm daily was started, with subsequent return to normal temperature and white blood cell counts in the next few days. This coincided with clinical improvement in the patient, and penicillin and streptomycin were discontinued after he had been afebrile for three days. Oxytetracycline hydrochloride was withdrawn a week later.

The patient remained afebrile with normal white blood cell counts for the remainder of his hospital stay. Subsequent chest roentgenograms revealed clearing of the left upper lobe pneumonitis, and serial electrocardiograms revealed stabilization of the anterior infarct pattern, although occasional ventricular premature beats persisted.

On October 30, phenobarbital 30 mg four times daily was restarted for one week. Three days later he noted a mild skin rash of the lower extremities accompanied by some pruritus, which cleared on diphenhydramine hydrochloride (Benadryl) 50 mg three times daily over the next five days. Serial white blood cell counts obtained during and after this period remained normal with normal differential white cell counts.

The patient was next seen eight months later when he was readmitted to the hospital for a contusion of the left hip after falling down some stairs. He was subsequently discharged after a course of physiotherapy. A white blood cell count was normal with normal differential, and a repeat electrocardiogram revealed sinus rhythm with occasional ventricular premature beats and evidence of an old anterior infarct. His only medication was digoxin 0.5 mg daily which he had been taking regularly since his discharge eight months previously.

DISCUSSION

In any drug induced blood dyscrasia, the final test to establish cause and effect relationship between drug and the dyscrasia would be to reproduce the disorder by re-administering the drug following hematologic recovery. Although this was contemplated, it was felt inadvisable as agranulocytosis was considered far too serious a complication, and procaine amide hydrochloride was strongly suspected as the responsible drug, particularly in view of the previously published reports.[1-4]

We felt reasonably certain that phenobarbital was not the causative agent, so this medication was repeated for one week in the same dosage following recovery from the agranulocytosis. Serial white blood cell counts throughout this period remained normal, although a slight skin rash developed which cleared following administration of diphenhydramine hydrochloride. Also, in reviewing the chart of an admission 10 months previously, it was noted the patient had received sodium phenobarbital 60 mg intramuscularly preliminary to cystoscopy without incident.

The marked elevation in white blood cell count which reached a peak on October 14 and a lesser peak four days later represented a myeloid reaction. As is frequently the case, this was preceded by a monocytosis which reached a peak on October 13. Oral oxytetracycline hydrochloride was added at the peak of this reaction, particularly in view of the rising temperature and roentgenographic evidence of pneumonitis of the left upper lobe. This antibiotic was chosen in view of its apparent beneficial effect in a patient reported previously under similar circumstances.[1] It is difficult to determine definitely whether or not further benefit was derived from the addition of this latter drug; however, temperature gradually fell to normal in the next four days, and the white blood cell count reached normal values in the next eight days.

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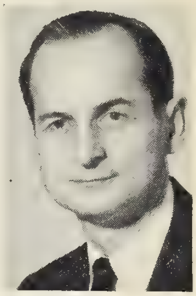

SUMMARY

A case report of a 71-year-old white male is presented who developed agranulocytosis following 11 weeks of procaine amide hydrochloride therapy, with subsequent recovery. Procaine amide hydrochloride remains an effective drug in the treatment of ventricular arrhythmias; however, regular white blood cell counts should be performed on all patients receiving this medication, and particularly those on prolonged therapy. Any patient on procaine amide hydrochloride developing fever and/or sore throat should be checked immediately for evidence of agranulocytosis.

ACKNOWLEDGMENT

We are indebted to Mr. Earl C. Bartlett, Medical Illustration Service, for the illustration.

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The Problem of

I-D-E-N-T-I-T-Y

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The problem of identity is the object of great interest on the current American mental health scene. Increasing numbers of patients seen in physicians' offices present complaints which represent their feelings of not knowing who they are. Theirs is a troubled searching for an identity in an ever changing, demanding, confusing world.

The lack of identity is the current dilemma of man in America searching for his identity as an individual, as he is drawn into stereotyped roles within a highly organized and structured society. The philosophers of our time state that the character of our age is such that it seems to be producing a basic neurosis of disorientation, futility, mechanization and robotization. They also state that psychiatry can do nothing about such neuroses. I hope to illustrate in this paper a rational basis for my disagreement with this last contention.

This article is based on clinical material derived from the analyses of several patients who focused upon a search for an identity as they plaintively and repeatedly asked "Who am I?" The search for an identity has become as strategic in our time as the study of sexuality was in Freud's time. The patient of today suffers most under the problem of what he should believe in and who he should be; while the patient of early psychoanalysis suffered most under inhibitions which prevented him from being what he thought he was.

"I Don't Know Who I Am"

The following was said to me by a very sick patient: "I never made the grade completely in any one area. I've been intellectually asleep, emotionally immature and physically inept. I don't know who I am."

Or as reported by another patient: "I don't know who I am. I have been an imitation of my mother. I've done no thinking for myself. I have never done anything that would be *me* as different from others."

I have started this exposition of the problem of identity with two examples from sick people because it is medical history that the normal becomes understood only after an understanding of the pathological has been accomplished. How the normal heart operates was understood only after doctors investigated pathological heart functioning. Such is also the pattern that developed in understanding normal mental functioning.

To illustrate, the following is a clinical brief of a pathological identity. This is a story of a woman who entered psychiatric treatment because she was suffering from severe attacks of anxiety which caused physical incapacitation. Her opening interviews, accompanied by crying and shaking, expressed fears of her husband becoming deathly sick. This abnormal concern for her husband proved to be an expression of her hostility against him, for it was followed by a period of innumerable complaints against him. She claimed that he was cold, unloving and did not want to do what she wanted him to do. She blamed all her symptoms on her husband not loving her as she wanted to be loved. She attempted to show that he was inadequate.

Had No Identification as Mother

As the interviews produced more material it became obvious that it was she who lived a dependent parasitic life, with her husband as her host. She wouldn't walk on her own two feet and go in the direction she wanted to go. If she tried to do anything on her own, she developed severe physical symptoms of diarrhea, frequency of urination, nausea and vomiting. After the birth of each of her children, she had to force herself out of bed in order to take care of them. She was cold, critical and hostile to her children. She had no identification as a mother of her children.

Her analysis uncovered tremendous hatred against her own mother who because of an inadequate husband had worked all her life, while ignoring the children. The patient's reaction of hatred against her mother caused her to swear to herself during her childhood *never to be like her*

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mother. This serious struggle against identification with her mother resulted in no emotional growth and a fixation in the inadequate parasitic baby position from which we all start life. The child is born without an identity; he achieves one through his contact with the world around him. A woman cannot feel feminine or motherly or adult if she doesn't have some identification with an adult mother.

Hostility Ruined Her Plans

During treatment, this patient, trying to progress, entered into club activities and charitable work, became panicky and quit. When she went out as a guest to a country club, she became panicky and drove home. She attempted going to college to become a teacher to gain independence; she couldn't concentrate on her reading, became panicky and quit. This turned out to be her pattern. She depreciated every area of endeavor. Her hostility destroyed every plan and prevented any creativity of her own.

This woman was mentally ill, in the psychiatric sense did not know who she was, with no sense of identity because she had not even one adult identification. It turned out that her underlying identification was that of a puking, diaper-soaked baby who demanded that she be taken care of by others.

A healthy personal identity is necessary for mental health. Any one of many identities may be normal. But a minimum requirement of any healthy identity in the American culture as derived from the sick identity presented above would be one based on a recognition that an individual should be able to stand on his own feet without making undue demands or impositions upon others.

Let's Define the Terms

It would be best at this point to define the terms *identity* and *identification*.

Identification is the process by which we appropriate and absorb in our own personality certain (actual or imagined) values and characteristics associated with others. Through a sort of coalescence of our personalities with persons or objects in the outside world, their purposes or qualities are felt to be our own. There are several different identifications which have to be integrated in order to allow the establishment of a personal *identity*. A normal person does not have several identities but rather these develop into an hierarchically organized psychic entity that finds expression in the state of personal identity. Throughout childhood, there is an interrelated development of object relations, identifications and identity with a resulting definition of the concept of identity.

The term identity has two significant faces—an inner and an outer one. The inner face refers to the specific characteristics which that individual has chosen for himself.

Needed An Inner Face

For example, before this patient married and had children she should have chosen an identification as a mother and a wife to the best of *her* abilities. This would have given her an inner aspect of a healthy identity. The inner face is maintained by an individual whose parts are sufficiently well integrated that the effect is of a genuine oneness. In other words, to be successful the individual must be at one with himself in his identifications.

The patient described was not at one with herself since though she was a wife and a mother, she wanted to be a baby. She couldn't be either a wife or a mother or a college student or anything as long as she resented not being a baby and not being mothered by her husband, children, parents, and friends. She couldn't be anything adequate and she remained like a newborn baby—a nobody.

One cannot live adequately today if one continues to live in the fantasies of one's nursery years.

Now, let's turn to the second, or outer face of identity, which refers to the unique characteristics of an individual person whereby he can be distinguished from other similar persons.

Needs Outer Peace, Too

Here the emphasis is on specific differences. Our characteristics and abilities are checked out against other people's. When this is done we hear spoken, "He's a hard worker" or "He's a good lawyer" or "He's active in community affairs" or "He's a good parent." Of course we may also have such comparisons as "He's so cold and distant" or "He never does a thing for others."

Testing oneself in comparison to other adults means accepting the necessary competition with other adults like one's parents. In other words, although the sense of the self-image comes first and is most important, it is maintained and perhaps

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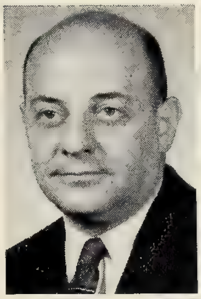


Many patients present themselves to physicians with physical symptoms resulting from an underlying psychological problem of a lack of identity. The search for an identity has become as strategic in our time as the study of sexuality was in Freud's time.

This paper exposes the problem with clinical examples from sick people whose chief complaint was "I don't know who I am." By use of an analogy with a wheel, both the inner core of identity—the struggle between love and hate and the many secondary identifications are delineated in illustration of the utilization of one's resources to develop a sense of identity.

vitalized and sharpened by the continual refinement which accompanies comparison and contrast with others. For example: "I have worked to become as good a father as my father," strengthens an inner identification.

Both aspects of identity, inner and outer, are continuously at work.

Our American culture has evolved in the framework of a family constellation. From this, it can be seen that an adequate role in the family unit is essential to a healthy identity for most adults. The efficiency of the family is dependent upon the capacity of each parent to fulfill his or her respective role with the unit completed by the interaction of father, mother and child. The family unit not only provides a growth-stimulating environment for the child, but also an equally growth-stimulating environment for the parents. The family thus provides an opportunity for healthy identifications. Women can find creative expression for themselves through the effective expression of the natural impulse to be a wife and a mother.

A recent development has been emphasis on the role of the father in the development of the psychological health of the child. Although his role as a parent is not considered as important as the mother's in the early years of the child's life, it is essential in the childhood and adolescent period. For men, the home is also an important source for healthy identification.

Men Relate to Job

Traditionally, however, men establish their identifications in their job. Being "a good provider" is an important identification in economic-conscious America. Knowledge of mastery of one's occupation is very important. Men patients often complain of being "a so-so engineer" or "a so-so lawyer" or "a so-so father and husband." These men are not proud of themselves. They may describe themselves as jack-of-all trades and master of none.

Establishment of one's self in at least one area is essential. Unless this occurs these men feel neither established in the home nor in their occupations. Their self-depreciatory attitude often turns out to be a result of having done everything in order to get approval, good marks or merit badges. They weren't doing what they, as individuals, wanted to do. They were doing what was duty or expected of them. Other men doing the same things felt good because it was an expression of their individual identity as an adult. The sick group related success only in terms of external goods—praise or criticism. The healthy group related success to doing what they wanted to be doing.

Need to Be Loved

Knowledge of ability to love is an important foundation for the healthy establishment of an individual's identity. Popular songs often express important themes in human life. There was a recently popular song in which the singer laments, "You're *nobody* unless somebody loves you." This is how sick people really feel. But the facts are that a person feels like a nobody unless he loves somebody besides himself. You're nobody as long as you keep demanding to be loved.

In another popular song the singer claims, "It takes an awful lot of loving to make my life complete." Some people depend on others to complete their identity. An independently healthy individual knows who he is because he can give an awful lot of loving which really makes one's life complete. This involves a capacity for complete trust in the other person but an even more important trust in oneself and in the security of one's identity. The family canvas which I have just painted, though focal to the problem of identity is not the only answer. It is the focus, or the matrix around which many identifications revolve.

But what of people who never marry, never have children, or who are unhappily married? Does this mean healthy identifications for them are impossible?

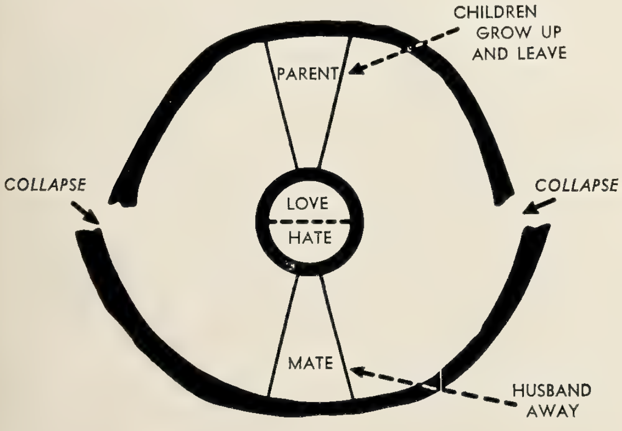
Obviously not! Innumerable identifications and sublimations are available outside the family. Also, is the family identification, even if successful, always sufficient? Not necessarily. We often see the picture of depression occurring in previously apparently healthy women over forty. It may occur at an age when her children begin to leave home and her husband is at the peak of his involvement in business and community activities which keep him away from the home. With the loss of identifications, her previous identity may melt away. A woman should not be only a mother and a wife, important as these roles are.

Need to Be Well-Rounded

From childhood on it is a natural tendency for individuals to concentrate on and develop in those areas of personality where they have a natural aptitude and for which they get the most recognition. This leads to development of those aptitudes which are easiest or which bring the greatest rewards.

This can lead to hyperdevelopment of a single area instead of developing in many areas. Such an approach leads to unfortunate avoidance of areas in which one is not naturally adept. It is well to be able to participate in areas where one is not and never will be as good as others and to be able to enjoy them and accept this reality as natural. Then the individual need not be one-sided. He can approach the ideal of a well-rounded individual capable of participating in and understanding many areas of life. He can form multiple identifications.

In men reaching the retirement age, we often see depressions developing or even quick deaths after their retirement. Such men have put all their eggs in one basket—an identification only as a worker. They suffer a loss of identity with the loss of their job.



MENTAL COLLAPSE
FROM INSUFFICIENT SECONDARY IDENTITIES

Fig. 1.

If a woman should not be only a wife and a mother, then a man should not be only a husband, father, and worker. He could also be a citizen, a member of boards of social agencies, an active member of a league of voters, a PTA member, a reader of novels and philosophy, a member of a religious institution, a friend and neighbor.

Long before the time comes when the family grows up, development of the individual's other capacities is essential to develop further successful identifications.

The unfortunate patient described at the beginning of this paper, in addition to failure in her family circle, could not make identifications outside of her family. A few identifications could have prevented her mental breakdown. Success in any one or two areas is enough for mental health. The human body is marvelously built. Nature so devised it, that there are large margins of safety against fatal illness. For example, there are two kidneys. If one is damaged the second can work enough for two. So it is with mental health. If identifications in the marital area or sexual area fail, other identifications are available for reserve to take up the slack.

This is the beauty of nature and the beauty of multiple healthy identification.

Good Life Like the Wheel

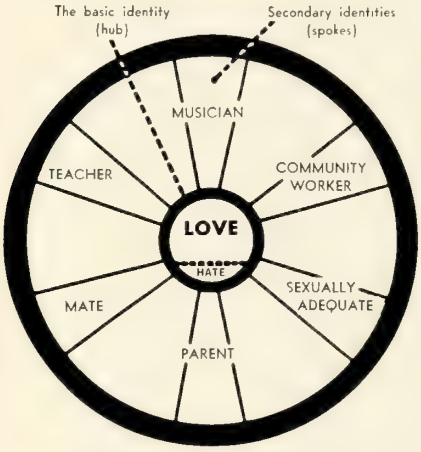
I would like to summarize what I have just said by an analogy. No doubt you have heard the expression, "Everybody wants to be a wheel." What does it mean? It means everybody wants to be a somebody. Everybody wants to be able to make things move. Everybody wants to have an adequate identity. It is when this natural human drive is sidetracked that sickness develops.

The discovery of the wheel by primitive man was one of the greatest steps forward in our civilization. It is the wheel which I wish to use now as an analogy of mental health. Try to visualize a large wagon wheel such as the pioneers used to cross this country. It had many spokes radiating from the hub outward. This was for the purpose of safety in numbers. If in the course of covering the rough terrain a few spokes were broken, the others could carry the load. If too many were broken before repairs could be made the wheel collapsed.

So it is with identifications and mental health. If a woman knows she loves her family, is a good mother, wife, homemaker and is sexually adequate, she has so many solid spokes, so many adequate identifications. She can cross continents no matter what the terrain because there is safety in numbers. In addition, or perhaps in place of these, can be added other solid spokes or identifications.

To continue my analogy, progress in the structure of wheels has been made from those used in the covered wagons to wheels used in modern automobiles. The change has been from widely separated wooden spokes to increasing numbers of metal spokes, to spokes that were so numerous they were almost solid, to the currently used solid wheel, which is another way of saying innumerable spokes.

This would be the formula for mental health. The individual should develop all the capacities within him in as many areas as is possible. This results in innumerable spokes (identifications) welded into an integrated oneness (identity). Then there will be no doubt as to who he is, come what may.



THE NORMAL WHEEL
OF MENTAL HEALTH

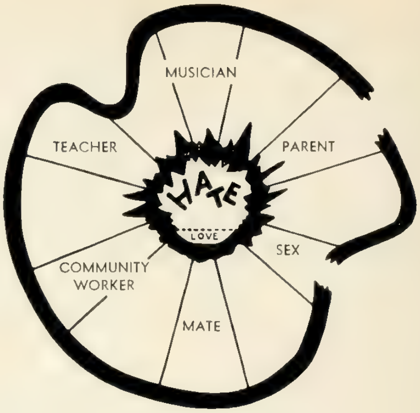
Why Emotional Collapse?

Now, I have shown you how important it is to develop multiple spokes or identifications in order to maintain mental health in spite of the pressures and vicissitudes which fate has in store for each of us during various stages of our lives.

We might consider this the whole of the story but it is not. There are some people who are very talented, very versatile, and hard workers. In other words, they build multiple spokes and identifications which stand them in good stead for years. Then something happens and they have an emotional collapse.

What happened?

Let us go back to the analogy of the wheel. In the example which I have just given, many healthy spokes were built but the wheel collapsed. Why? It is because all spokes of a wheel are connected to a central hub. The hub of the wheel must be strong and sturdy in order for the spokes to be effective. If the core of the hub is rotten, the spokes collapse from the inside.



MENTAL COLLAPSE FROM WITHIN
BASIC IDENTITY IS LOST

How does this happen?

To explain this to you I will go back to my sick patient. I showed you how her sickness was due to an inner hard core of hatred for her parents that dominated her life. Everything she tried to do, every spoke which she attempted to develop in order to know who she was, was destroyed from within. The important inner hub was made rotten by hatred. Again, this example from sickness allows us to know what normal is. Normal is the ability to love which forms the healthy hub through which healthy spokes can operate effectively. This all-important central hub or identification is the knowledge that one can love. This is normal.

Learning to Love So Essential

Loss of identity may be a loss of defensive identifications (ego identity, social identities, spokes of the wheel). The basic identity is the awareness on one's part of his capacity to love. What in the adult is referred to as his social identity or ego identity—being a worker, farmer, hunter, etc., is at best what the individual loves to do. At its worst, it is an artificially imposed part, the playing of which is experienced as alienation by the individual, because it is incompatible with his basic identity.

Those individuals who were fortunate in their early years to learn to love more than to hate are able to build spokes which revolve around a hub that is solid. Those who are less fortunate must work desperately to overcome the handicap of their hatred, to eliminate their hatred, and to develop the vital capacity to love, from which foundation their spokes will move the world. For if it is true that "love makes the world go round," it also is love that makes our individual wheels go round.

This is how "Who am I?" is the hub and wheel of mental health. The quest for identity is either the search for new defensive organization or for access to the one value which is not culturally determined, the capacity to love. This is what the philosophers don't recognize. This is where psychiatry can help the individual resolve the current neuroses incorrectly attributed to cultural forces by philosophers.

One important psychoanalytic concept is that of a psychic mechanism called sublimation. It refers to a psychic mechanism that utilizes instinctual drives that may not be socially acceptable *per se*, in a manner that leads to socially more valuable activities. All the examples given previously in this paper such as being a parent, a teacher, a community worker involve activities made possible as a result of sublimations. These all important sublimations were made possible because of identifications. It is a psychoanalytic axiom that all sublimations utilize identifications.

The spokes of the wheel which I have described are the result of secondary identifications which allow for successful sublimation of instinctual drives. They are very important to one's mental health.

The hub of the wheel is even more important. In it, if it is healthy, resides the basic, primary identification: "I can love." The problem of ambivalence is involved in the hub. Varying balances between love and hate take place here. When the conflict is solved in favor of capacity to love, this all important basic identification together with social identifications allow for resulting healthy sublimations and a healthy identity.

Love Is Vital Hub

If the hub is solid with love, a few secondary identifications will suffice as spokes to keep the wheel rolling. If the inner core is corroded by hatred, many adequate spokes will collapse at their point of union with the decayed hub. The hub of the wheel is not culturally oriented. The spokes of the wheel are.

To complete the analogy of the wheel, we should speak of the rim of the wheel. It is the outer face of identity. It is the point of contact of the identification with other people that smooths and tempers the surface of our personalities. The rim is the resultant of all that is on the inside and is the boundary through which the outer world experiences the various spokes or secondary identifications of the many sides of the individual's personality.

In summary, I have used clinical material to present the complexities of the problem of identity and to illustrate the utilization of one's resources to develop a sense of identity.

More Physicians in Postgraduate Training Now than Students in Medical Schools

For the physician of the future, formal education may be a continuum rather than a prelude, declared William L. Kissick, M.D., staff assistant to the special assistant to the secretary of the Department of Health, Education and Welfare, at a MSU conference.

Observing that medical specialty organizations are setting higher and higher standards based on formal education requirements, Doctor Kissick said that the time may come when postgraduate education will be required for continuing in practice.

Doctor Kissick told students that five years after they receive their M.D. degrees, 43 per cent of them will still be training.

There are already more physicians in postgraduate training than there are students in medical schools, he noted. In 1964, he said, there were 39,000 doctors in training as interns and residents as compared to 32,000 students in the nation's 87 medical schools.

Social trends affecting medicine's future, he said, are population growth, urbanization, mobility of families, better educated citizens, automation, constant change, and the exponential growth of science.

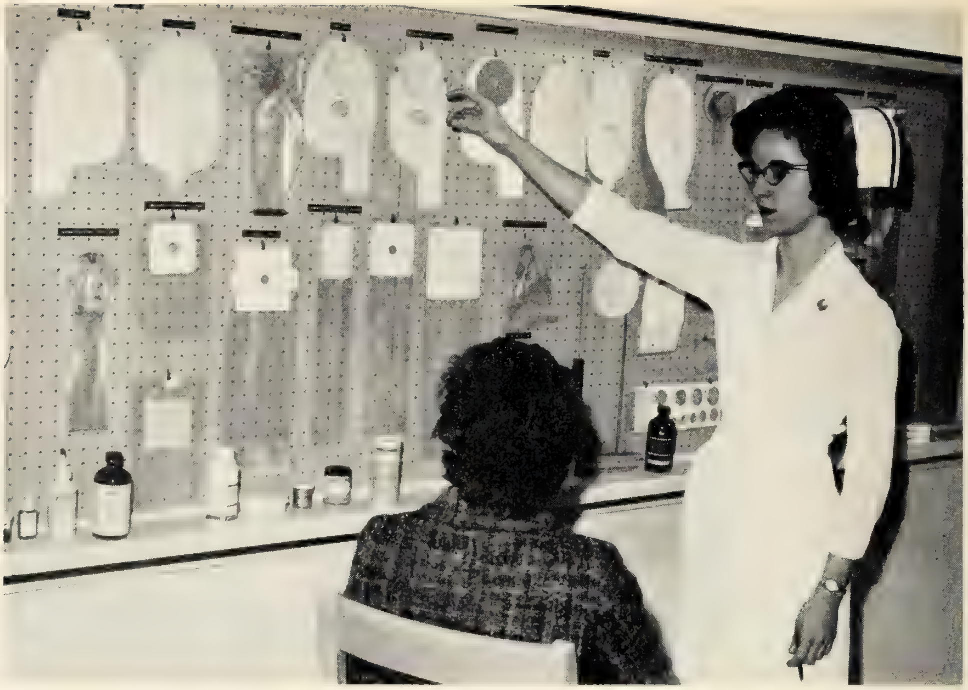


Figure 1. Above shows display panel exhibiting different types of ileostomy and colostomy appliances.

A *New* CONCEPT IN PATIENT CARE: ABDOMINAL STOMAL THERAPY

By

JAMES P. MULDOON, M.D.*

GRAND RAPIDS

Since 1961 the Ferguson-Droste-Ferguson Hospital in Grand Rapids has been in the process of organizing a new department in an effort to assist the physician in his treatment of patients with colostomies and ileostomies. This department has been named the Abdominal Stomal Therapy Department.

The care of the patient with a temporary or permanent opening on the abdomen for the excretion of feces or urine presents many and varied problems. The colostomy or ileostomy patient is often left to care for himself and adapt without benefit of adequate preoperative preparation or thorough postoperative instruction and training.

The department of Abdominal Stomal Therapy has attempted and has been reasonably successful in anticipating the needs of these patients. The factors to be considered are physical, mechanical, and emotional. All of these handled properly lead toward understanding and complete rehabilitation of the patient.

The patient, having first been seen and diagnosed by his physician, is advised of the necessary corrective surgery, emphasizing that an abdominal stoma in the form of a colostomy or ileostomy is absolutely essential for successful treatment and cure. The doctor then assures the patient that a representative from the Abdominal Stomal Therapy Department will follow him closely. Admission to the hospital is arranged and the Abdominal Stomal Therapy Department is notified. Seeing the patient at this time eases the patient's mind and helps to repair his emotional status. Much kindness and understanding is needed for the patient's acceptance of his plight and future outlook.

At the proper time during the preoperative workup the patient and members of his family are taken to the Abdominal Stomal Therapy Department. At this hospital two

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*Active Staff, Ferguson Clinic, Grand Rapids, Michigan.

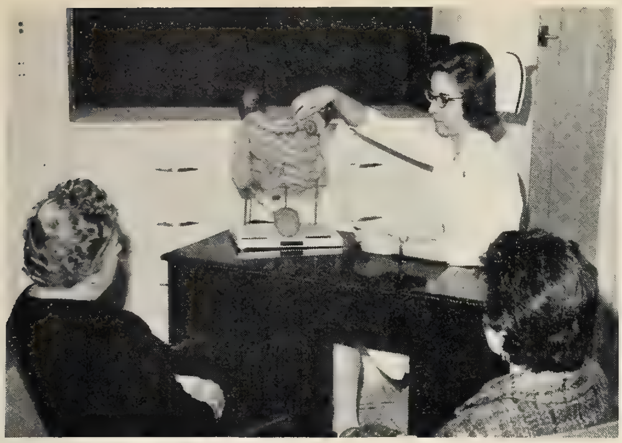

Figure 2. This shows patient and family being instructed using plastic model of human anatomy.

rooms have been set aside for this service. These rooms are well lighted and cheerfully appointed. One room contains an examining table that can be used for close examination of the abdominal stoma and for treatment. The other room is used exclusively for teaching and contains a display panel that can be covered exhibiting every ileostomy and colostomy appliance commercially sold. (Figure 1.)

The display also has samples of the various cements, solvents, skin conditioners, and other accessories that are needed in stomal appliance fitting and care. Present also is a large, full-length wall mirror that is essential in teaching the patient proper application of his stomal appliance. (Figure 2). Regular display mannequins with mockup colostomy and ileostomy, along with a plastic model of the human anatomy, form a most vivid and accurate aid in the education of the patient and the family. (Figure 3). The instructions are carried out slowly and in an informal and understanding manner.

As questions arise in the patient's mind other visits to the department are undertaken so that, as far as possible, absolute understanding may be achieved.

The Abdominal Stomal Therapy Department has recruited and compiled a list of individuals who have either a colostomy or ileostomy and who are very eager and interested in helping orient and reassure the candidate for an abdominal stoma. These aides see the patients preoperatively and offer them reassurance and confidence that their plight is compatible with a full and active life.

> *The patient is often told before calling in one of these aides, "If you doubt or have any fears about having a colostomy or ileostomy, why don't you talk with a person who owns one? These aides are surprisingly easy to recruit and play a most important role in patient preparation and rehabilitation.*

Along this same line the patients are issued by the stomal therapist a small manual that is simply written and contains general information about the ileostomy and the colostomy. The most basic questions are asked and clearly answered in this manual.

Postoperatively these patients are followed daily by the stomal therapist. The progress and maturation of the stoma are observed with the surgeon. When the doctor orders an appliance the therapist measures, obtains and fits the appliance to the patient. During this period the patient, if the doctor so desires, is taught irrigation of his colostomy.

Slowly the patient is taught self care, so that when he is discharged he will have been caring for his own stoma for several days and will have gained the confidence and skill needed. At the time of discharge the patient is informed that a stomal therapist is on call at all times for personal or telephone counseling. Information is also given as to where and how to acquire dressings, appliances, and accessory items.

Follow-up is made when the patient comes to the doctor's office for his checkup or simply for additional stomal therapy. An active file on each patient is kept, beginning at the time of his hospital admission. Notations are transcribed each time the patient is seen. Reference is made frequently to this file for evaluation of progress.

This department has seen approximately 200 patients in two years. In orienting, educating, and rehabilitating the patient, economy is also considered, although service is the primary goal. Nearly all of the appliances used for display have been donated free of charge by the various companies that make them.

Different sized dies or cutters have been purchased that allow the hospital to cut Neoprene foam pads from bulk sheets—saving the patient considerable cost. These pads normally cost the

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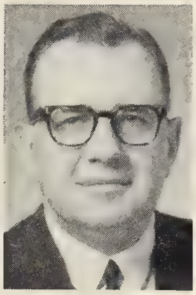

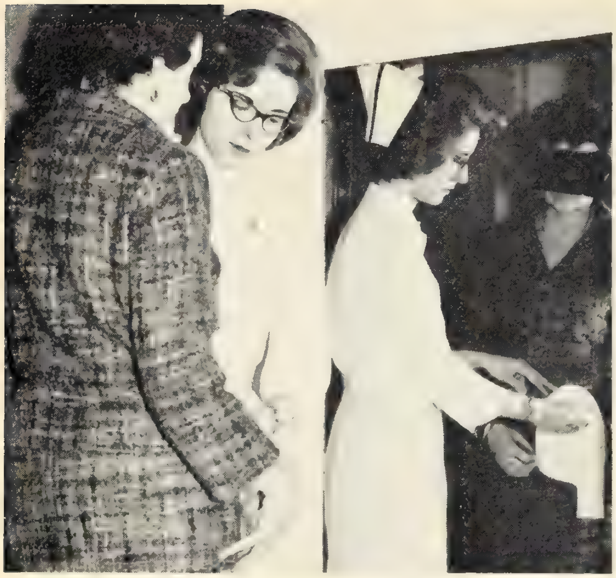

Figure 3. This shows patient being instructed in application of ileostomy appliance before mirror.

patient 25c each. We can now cut them ourselves with a charge to the patient of only 10c each. Solvents needed in changing and applying stomal appliances are purchased in bulk quantity at a considerable saving.

> *The services of the Abdominal Stomal Therapy Department are offered to the community in the same spirit as any rehabilitation service. It is felt that this department can play an integral part in assisting and adding to the student nurse teaching programs.*

The various outlying cancer societies have expressed an interest in this project. Many local physicians are taking advantage of this service for counseling of their patients along with application of different or newer stomal appliances. Resident and intern physicians have found that observation in this department is helpful and needed in order to fully understand the colostomy or ileostomy patient.

The value of this new department can be realized more fully after talking to patients who had colostomies or ileostomies instituted before the department was established. They attest to the fact that the department is greatly needed and that they would have been much better off if they had had access to it during their preoperative and postoperative stages.

Actually this department has been a most gratifying experience for the therapist who is able to observe patients assuming a healthy and satisfactory attitude toward a new way of life.

Dow Corning Center Lists New Research Experiments

(Following are excerpts from the Fifth Annual Report of the Dow Corning Center for Aid to Medical Research.)

"Many of the individual projects in which we have been involved this year are in the early evaluation stage. Some are strictly experimental, others are now in the animal experimentation phase, while still others are ready for limited clinical evaluation. A few have reached general clinical usage.

"Some of the more significant applications are:

"1. The use of Silastic silicone rubber and silicone fluid for the prevention of pleural and abdominal adhesions.

"2. Artificial tendons made of reinforced Silastic silicone rubber and the use of thin Silastic rubber sheeting for the prevention of adhesions in tendon repair.

"3. Silicone rubber contraceptive devices for long-term placement.

"4. An internal splint for keeping the Fallopian tube patent after surgery.

"5. The design and fabrication of an artificial implantable heart.

"6. A transparent corneal prosthesis.

"7. The encapsulation of many types of implantable transducers, strain guages or other devices for monitoring physiological systems. The encapsulation protects the devices from the body and insures compatibility of the device with the body.

"8. The design of improved heart valves.

"9. The building up of the alveolar ridge for those unable to tolerate dentures.

"10. A permanent soft denture liner.

"11. Materials for the repair of orbital floor fractures."

Praises Family Doctor In Testing New Drugs

The important role of the family doctor in evaluating new drugs was stressed by Theodore G. Klumpp, M.D., at the 17th scientific assembly of the American Academy of General Practice in San Francisco.

Doctor Klumpp, who has spoken at the MSMS Annual Session and is president of Winthrop Laboratories, said, "We must depend upon alert general practitioners to detect the rare-one-in-a-hundred thousand or one-in-a-million side effects or idiosyncrasies that may occur with respect to even the safest drugs."

"I maintain that an experienced physician can tell if a drug puts a patient to sleep, relieves pain, stops a cough, relieves an itch, lifts a depression or improved movement in arthritis—without placebos and double-blind controls," Doctor Klumpp said.

NOTE ON The Scalene Node and The Problem of Sarcoidosis*

By
ALBERT DEGROAT, M.D.
MORRIS WHITE, B.S.
BOTH OF DETROIT

Sarcoidosis has a long involved history and appears under a variety of names. Darier in 1896 described a dermatological condition which Boeck in 1899 described in a slightly different clinical form, applied the term sarcoid and justly got his name attached to it. An argument ensued which was resolved when the two authors exchanged slides and decided they were seeing the same disease.

Schaumann in 1914 demonstrated that sarcoid ("benign lymphogranuloma") was a systemic disease clearly separate from the known infectious granulomas, notably tuberculosis with which it had become identified as one of the "tuberculids" (Darier[2]). Here the matter has rested for 40 years with the etiology completely obscure.

* * *

THE PRACTICE of scalene node biopsy was introduced by Daniels[1] and Shefts[4] to clarify the nature of pulmonary lesions which at times the node reflects. When significant changes occur these are most frequently epithelioid tubercle-like lesions which lend themselves readily to a diagnosis of sarcoid.

"Scalene node" more often than not is a manner of speaking, the specimen consisting of fat in which are disseminated collections of lymphoid tissue. Culture in this circumstance not being feasible, the examination is histological alone and this leaves the etiology unsolved.

In a previous study of fluorescent staining of mycobacteria,[3] numerous scalene nodes containing non-caseating granulomas were recut and reviewed but were set aside for a special project, namely, to check the validity of the diagnosis of sarcoid.** However, it was soon learned that no conclusions could be drawn on a short-term basis.

* * *

CONSEQUENTLY, AFTER a lapse of two years, a selection of cases was made in which sufficient material had been received to attempt culture and the records of the tuberculosis clinic, where a tight control program is maintained, were examined to learn in what manner the patient's disease had evolved. Twenty-two cases answered our purpose:

1. All patients had at one time or another been suspected of having sarcoidosis.
2. None had had a positive sputum.
3. Stains (rhodamine and auramine) revealed acid fast rods in nine specimens (two of them had been positive by Ziehl-Neelsen).
4. Five specimens were doubtful; that is to say: fluorescent objects were too few and badly oriented to permit a certain conclusion.
5. No specimen yielded a positive culture.

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**Periodic acid-Schiff stains have been done routinely for about ten years. No fungi demonstrated in this group of patients.

6. Eight specimens were negative for acid fast organisms.

* * *

THE FOLLOW-UP of the patients revealed:

1. Ten records were closed with a diagnosis of sarcoid; all patients have remained well.
2. Eight patients, for various reasons, were treated for tuberculosis by drugs; all have remained well.
3. Other diseases: one carcinoma (and tuberculosis); one probable histoplasmosis (in #2 above); a cardiac anomaly (in #1 above).
4. Probable minimal tuberculosis with minimal activity (based chiefly on the x-ray character of the lesions; one cavitary) five cases (also in #1).
5. Evolved into manifest tuberculosis: three cases, one of lupus vulgaris; disease mild, all now in good health.

CONCLUSIONS

1. A non-caseating granuloma in a scalene node usually means a favorable prognosis regardless of the etiology.
2. This finding is useful as a lead to further investigation but is not diagnostic.
3. Fluorescent staining for acid fast bacilli is a useful addition to existing means of diagnosis.
4. Tuberculosis continues to haunt sarcoidosis as it did when the pioneers were struggling with the problem.

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Anorectal Malformations

By JAMES R. LLOYD, M.D.*

Recent embryological and anatomical investigations suggest that re-evaluation of anorectal anomalies, from both a diagnostic and therapeutic point of view, is long overdue.

Embryologically, anorectal anomalies are the result of an arrest in descent of the termination of the colon from its initial location high on the posterior wall of the cloaca to a definitive position on the perineum. The point of arrest is an ectopic anal opening and may communicate with the bladder, urethra, vagina, or perineum depending on the patient's sex and level of arrest. An arrest in descent of the anus above the levator muscles constitutes the high ectopic anus and all such cases should be treated by colostomy at birth followed by a combined abdomino-perineal pull-through operation with division and closure of the ectopic communication when the infant is 15 to 18 months old. An arrest of the anal descent below the levatur ani muscles comprises the low group of anomalies which may be approached from below. When the bowel has descended below the levator sling, the encircling fibers of the pubo rectalis muscle insure continence so long as this relationship is not disturbed.

In high anomalies, the bowel remains above the pubo rectalis fibers and continence can be obtained only by bringing the bowel through the encircling fibers of the pubo rectalis immediately posterior to the urethra in the male or vagina in the female. This is the most critical point in the operation.

The archaic method of measuring the distance from the theoretic site of the anus to the lowest point of the rectal pouch is not reliable in differentiating the high from the low anomalies. This maneuver should be abandoned and a method of determining this distance based on anatomical landmarks should be adopted. For instance, a line drawn from the tip of the coccyx to the undersurface of the pubis approximates the pubo coccygeal line and the relationship of the rectal pouch to this line determines whether the anomaly is of the high or low variety, regardless of the pouch to skin distance.

With the exception of the membranous anal atresia, a communication of the bowel at some point along the line of theoretic descent of the anus should be expected in every patient. Failure to find such a communication has been overlooked.

Based on more recent anatomical and embryological data—a new classification of anorectal anomalies is suggested.

I. Anal-rectal stenosis
II. Membranous anal atresia
III. Intra levator ectopic anus
    Recto-vaginal communication
    Recto-urethral communication
    Recto-perineal communication
IV. Supra levator ectopic anus
    Recto-vesicle communication
    Recto-vaginal communication
    Recto-urethral communication
V. Persistent cloaca
VI. Rectal atresia

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Presented to the Detroit Surgical Association.

Contact Dermatitis Due to Topical Hydrocortisone and Prednisolone

By
Ralph J. Coskey, M.D.
Detroit

There have been very few reports in the literature of contact dermatitis due to hydrocortisone or prednisolone. Sams and Smith[1] reported a case of contact dermatitis due to hydrocortisone ointment, but their patient was found to be allergic to emulsifying agents in the ointment base. Kooij[2] described a patient sensitive by patch testing to hydrocortisone and prednisolone. Burckhardt[3] found a patient sensitive to hydrocortisone acetate but not prednisolone. Dorn[4] also reported a patient allergic to hydrocortisone acetate.

Church[5] discussed five patients sensitive to hydrocortisone acetate ointment. These patients on further patch testing were actually found to be allergic to 21-diol acetate, a precursor of hydrocortisone acetate. This product was found in small quantities in the final product.

The purpose of this paper is to discuss two patients seen recently, one who was allergic to hydrocortisone and prednisolone topically and the other who was allergic to topical hydrocortisone, but not prednisolone.

Report of Cases

CASE I. A 14-year-old white boy was first seen on April 23, 1962, because of a pruritic eruption involving the right ear, right postauricular area and the right side of the neck. The eruption had started in the right ear canal 30 days previously. At first it improved with the use of drops containing neomycin sulfate and sodium propionate (Otobiotic Drops, White), but soon relapsed. Therapy was then changed to drops containing polymyxin B sulfate, neomycin sulfate and hydrocortisone (Cortisporin Otic Drops, Burroughs Wellcome). These were stopped because of an exacerbation of the dermatitis, and the therapy was then changed to colloidal oatmeal compresses (Aveeno Colloidal Oatmeal, Aveeno Corp.) with improvement. However on April 5, 1964, the ear once more flared. Because of this iodochlorhydroxyquin-hydrocortisone cream (Vioform-Hydrocortisone Cream, Ciba) was used topically with the appearance of new areas of involvement on the neck, ear and postauricular area.

* * *

PHYSICAL examination revealed an erythematous, weeping crusted eruption involving the right ear, right postauricular area and the right side of the neck.

After being seen on April 23, 1962, the patient was treated with Burow's solution compresses (Domeboro powder, Dome), 0.1 per cent triamcinolone acetonide cream (Kenalog, Squibb), dexbrompheniramine maleate (Disomer, White) and corticotropin purified (Cortrophin Gel, Organon) and improved. Therapy was then changed on April 27, 1962, to 1 per cent hydrocortisone cream (HC Cream, C and M Pharmacal) and within a few days the eruption exacerbated, appearing not only on the previously involved areas, but also on the superior aspect of the chest and back. Therapy on May 4, 1962, was then changed to Burow's solution compresses, 0.1 per cent triamcinolone acetonide cream and dexbrompheniramine and the eruption resolved.

* * *

CASE II. A seven-year-old white boy was seen on March 17, 1964, because of a pruritic eruption involving the ears. It had been present three and one-half months. He was given a cream to use topically containing ½ per cent neomycin and 1 per cent hydrocortisone, (1 per cent NeoCortDome Creme, Dome). After using it for one and one-half days the eruption became much worse. The eruption was then treated with .025 per cent fluocino-

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lone cream, (.025 per cent Synalar Cream, Syntex) and Burow's solution compresses and it improved.

Comments

Both of the above cases were treated for otitis externa with topical neomycin-hydrocortisone preparations and promptly became worse. Reynolds[6] reported his findings on 28 cases of neomycin sensitivity and found that nine of the cases started after neomycin preparations were used topically for otitis externa.

At first it was thought that both of these patients were sensitive to neomycin. It was a surprise to find positive patch tests to hydrocortisone and negative tests to neomycin.

Case I had positive patch tests from hydrocortisone and prednisolone. This is not unexpected since prednisolone is a synthetic analogue of hydrocortisone, differing chemically only by having an additional double bond between carbon 1 and 2 of ring a in the delta 1 position.

It is difficult to explain why case II was sensitive to hydrocortisone alcohol, but not hydrocortisone acetate, since there is very little difference between the two molecules.

It is possible that the patients presented may have been sensitive to one of the precursors of hydrocortisone. However this could not be determined since they were not available for patch testing.

PATCH TESTS

	CASE I	Case II
1. 1% Hydrocortisone alcohol cream (1% CortDome Creme, Dome)	2+	2+
2. ½% Neomycin sulfate and 1% hydrocortisone alcohol cream (1% NeoCort-Dome Creme, Dome)	2+	3+
3. ½% Neomycin sulfate in Acid Mantle lotion (½% NeoMantle Lotion, Dome)	0	0
4. Acid Mantle Creme, (Dome)	0	0
5. 1% Hydrocortisone alcohol lotion (Hytone Lotion, Dermik)	2+	1+
6. 1% Hydrocortisone cream (1% Hytone Cream, Dermik)	1+	Not done
7. Base of Hytone Cream (Dermik)	0	Not done
8. 1% Hydrocortisone alcohol cream in Desitin cream (Desitin HC Cream, Pfizer)	2+	Not done
9. Desitin ointment (Pfizer)	0	Not done
10. 3% Iodochlorhydroxyquin cream (Vioform Cream, Ciba)	0	Not done
11. 1% Hydrocortisone acetate ointment (1% Cortef Ointment, Upjohn)	1+	0
12. ½% Neomycin sulfate and ½% Prednisolone acetate ointment (Neo-Delta-Cortef Ointment, Upjohn)	1+	0
13. ½% Prednisolone 21 phosphate ointment (0.5% Hydeltrasol Ointment, Upjohn)	2+	0
14. ½% Prednisolone in A and D Ointment (A and D Ointment, White)	2+	0
15. A and D Ointment (White)	0	Not done
16. ½% Prednisolone cream (Metiderm Cream, Schering)	2+	Not done
17. 0.1% Triamcinolone acetonide cream (0.1% Aristocort Cream, Lederle)	0	0
18. 0.05% Fluradrenolone cream (.05% Cordran Cream, Lilly)	0	0
19. 0.025% Fluocinolone acetonide cream (.025% Synalar Cream, Syntex)	0	0
20. 0.1% Dexamethasone 21-phosphate cream (0.1% Decadron Cream, Merck, Sharp and Dohme)	0	0
21. 0.25% Methylprednisolone acetate cream (0.25% Medrol Veriderm Cream, Upjohn)	0	0

Acknowledgements

The hydrocortisone preparations for patch testing were supplied through the courtesy of Dome Chemicals, Inc., Dermik Pharmacal Co., Chas. Pfizer and Co., Inc. and the Upjohn Co. The prednisolone preparations were supplied by the Upjohn Co., White Laboratories, Inc. and Schering Corp. Lederle Laboratories supplied the triamcinolone acetonide cream. Eli Lilly and Co. supplied the flurandrenolone cream. Syntex Laboratories, Inc. supplied the fluocinolone acetonide cream. Merck, Sharp and Dohme supplied the dexamethasone 21-phosphate cream. The Upjohn Co. supplied the methylprednisolone acetate cream. The iodochlorhydroxyquin cream was supplied by Ciba Pharmaceutical Co. Some of the above companies (Dome, Dermik, Pfizer and White) supplied the base of their preparations. Dr. Douglas L. Wake kindly referred Case I to me.

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Generic and Trade Names of Drugs

Hydrocortisone-Cortef, Cortifan, Cortril, Hycortole, Hydrocortisone.
Hydrocortisone Acetate-Cortef Acetate, Cortril Acetate, Hydrocortisone Acetate.
Prednisolone-Delta Cortef, Hydeltra, Meticortelone Meti-Derm, Paracortol, Sterane, Sterolone.
Prednisolone Phosphate Sodium-Hydeltrasol.
Neomycin-Mycifradin, Myciguent, Neomycin Sulfate.
Polymyxin-Aerosporin Sulfate, Polymyxin B Sulfate.
Chlorpheniramine Maleate-Chlor-Trimeton Maleate, Teldrin.
Iodochlorhydroxyquin-Vioform.
Triamcinolone Acetonide-Aristocort Acetonide, Aristoderm, Kenalog.
Dexbrompheniramine Maleate-Disomer.
Corticotropin Purified-ACTH Purified, Corticotrophin-Gel, Cortrophin Gel, Depo-ACTH.
Fluocinolone Acetonide-Synalar.
Flurandrenolone Acetonide-Cordran.
Dexamethasone Phosphate Sodium-Decadron Phosphate.
Methylprednisolone Acetate-DepoMedrol, Medrol Acetate Veriderm.

MSMS Salutes 24 Industries, And Businesses

Twenty-four representatives of the Michigan world of business, industry and communications will be cited by the Michigan State Medical Society, September 20 in Detroit.

The awards will be presented at the Sheraton-Cadillac Hotel as one of the highlights of the MSMS Centennial Observance in Detroit, September 19-24.

"We want to recognize the vitally important supportive role played by these Michigan leaders in business, industry and communications in working with our doctors toward providing the highest possible level of health care," points out Harold H. Hiscock, M.D., Chairman, MSMS Council. Doctor Hiscock, of Flint, has notified the firms and organizations and invited them to the award ceremonies.

Divisional awards will be presented to S. S. Kresge Company, for Business; Kellogg Company for Industry; and WJBK Radio and Television (Storer Broadcasting Company) for Communications.

Individual awards in the three fields will be issued to:

Business—Campbell-Ewald Advertising, Medical Exhibitors Association, Inc., Michigan Committee of the Health Insurance Council, The J. L. Hudson Company.

Industry—Chrysler Corporation, The Dow Chemical Company, Ford Motor Company, General Motors Corporation, Gerber Products Company, Gerity Broadcasting Company, Parke, Davis & Company, Pharmaceutical Manufacturers Association, Smith Kline & French Laboratories, The Upjohn Company.

Communications — Booth Newspapers, Inc., The Detroit Free Press, The Detroit News, Federated Publications, Michigan Association of Broadcasters, Michigan Chapter of the American Medical Writers Association, WJIM-TV of Lansing.

Take a Bow!

"RESOLVED BY THE HOUSE OF REPRESENTATIVES (the Senate concurring), That the members of the Legislature take this opportunity to express their sincere appreciation to the Michigan State Medical Society and the Ingham County Medical Society for their thoughtfulness and consideration in maintaining and staffing the medical first aid station for the convenience of the Michigan Legislators."

Once again a Concurrent Resolution was adopted by the Michigan House and Senate to show appreciation to the medical profession for the first aid station.

Doctors Invited To Join Writers For Convention

Interested Michigan physicians are invited to participate in the annual meeting of the American Medical Writers Association at the Statler-Hilton Hotel, Detroit, September 16-19. Coming to Michigan for the fine program will be outstanding writers, editors and technicians in the field of medical publishing.

Many Michigan physicians will appear on the program, which has been arranged by C. Howard Ross, M.D., Ann Arbor, Chairman of the Michigan Chapter, and convention program chairman.

Edward C. Rosenow, Jr., M.D., Executive Director of the American College of Physicians, will preside at the convention as the current president.

Replacement Sought For Doctor Terry

President Johnson has announced the resignation of Luther L. Terry, M.D., the Surgeon General of the U. S. Public Health Service, as of September 30. Doctor Terry will become Vice President of the University of Pennsylvania. The President said that he had not as yet selected a successor for Doctor Terry, but that he was looking for the "most adventurous and most imaginative doctor in this country" to be the Surgeon General. "I don't know where he is, but we're going to start looking for him," the President added.

COMPETE FOR INTERNS

Thirty Michigan hospitals vied at the University of Michigan in August to lure the 375 future doctors expected to graduate from the School of Medicine in 1966 and 1967. The hospitals told their stories with elaborate displays, multicolored booklets, colored movies and forceful physicians.

BORGESS HOSPITAL
KALAMAZOO.MICHIGAN

To Beam TV to Centennial

Subjects and speakers have been carefully selected to make the 1965 MSMS use of closed circuit, colored television at its Annual Meeting—the best ever!

Once again, Smith Kline & French Laboratories will bring its equipment and technical crews to Detroit to provide Centennial Session participants three telecasts, September 21-22-23.

To be beamed from Sinai Hospital to Room 2040 at Cobo Hall, the program has been arranged by a MSMS Committee on Television with Donald H. Kaump, M.D., as chairman again.

An in depth presentation of "The Pregnant Diabetic" will be offered from 4 to 5:30 p.m., September 21, with Fred W. Whitehouse, M.D., Detroit, as moderator.

The program at 10:30 to 12:30, September 22, will first deal with "Skin Changes in Blood Dyscrasias," with A. R. Axelrod, M.D., Detroit, as moderator; then with "Warts," with William B. Taylor, M.D., Ann Arbor, as moderator; and "Local, Regional and Block Anesthesia," with Robert B. Sweet, M.D., Ann Arbor, as moderator.

The cameras, on September 23 from 10:20 to 12:30, will cover "Pediatric Urologic Surgery" with Frank B. Bicknell, M.D., Detroit, as moderator, and then "Strabismus—Medical and Surgical Care," with John W. Henderson, M.D., Ann Arbor, as moderator.

Participants on the TV programs are physicians from Detroit, Ann Arbor, Grand Rapids, Midland, Los Angeles and Miami.

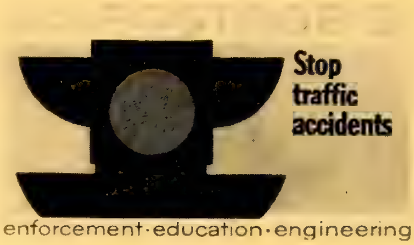
Where Did Interns Go in Michigan?

Reports from the two schools of medicine give the following breakdown on where the graduates are doing their internships in Michigan:

	U-M	WSU
Detroit	13	35
Ann Arbor	19	0
Grand Rapids	10	6
Lansing	2	0
Eloise	8	1
Dearborn	6	3
Kalamazoo	12	1
Midland	2	0
Highland Park	0	1
Muskegon	1	0
Pontiac	1	4
Saginaw	5	0
Traverse City	3	0
Grosse Pointe	0	2

EAST LANSING—The nation's only undergraduate program in hospital administration will be established this fall at Michigan State University.

The program, to be sponsored by a $99,480 grant from the W. K. Kellogg Foundation, will be on an experimental basis in the MSU School of Hotel, Restaurant and Institu-



"Stop Traffic Accidents" Is Postal Plea

Many Michigan physicians will be keenly interested in the issuance by the United States Post Office on September 3 of a traffic safety commemorative stamp.

MSMS has had a pace-setting state committee in the field of auto safety—and MSMS sponsored the 1964 AMA resolution on auto safety.

Michigan physicians eager to promote traffic safety will want to use the new 5 cent stamp. MSMS members agree with the stamp that "Enforcement, Education, Engineering Stop Traffic Accidents."

tional Management. Use of this commemorative stamp by physicians on their office mail can be an effective traffic safety effort.

Wayne County Pays Full Fees

The following excerpt from a recent issue of the Detroit Medical News is "good news" for all Michigan physicians:

George L. Reno, M.D., Chairman of the Committee on Welfare and MAA Fees, read the following letter from Walter Dunne, Director, Wayne County Department of Social Welfare:

"In compliance with your recent request, the Board of Social Welfare has agreed to lift the ceiling on fees paid to physicians on MAA (Kerr-Mills) cases effective July 1, 1965. This will mean that all such cases, which qualify under the regulations of the department, will be paid according to the Uniform Fee Schedule, without limitation. I trust this will be satisfactory."

ANN ARBOR—Todd Grant, University of Michigan senior medical student from Lathrup Village, is the new president of the Galens Honorary Medical Society. The Society of 35 members of the junior and senior classes of the Medical School is primarily a service organization for projects at University Hospital and Medical School.

More Reasons to Go to the Centennial

Luther R. Leader, M.D., Birmingham, will be introduced as the 100th MSMS President at the Tuesday night, September 21, meeting of the House of Delegates—and then formally installed at the Centennial Banquet, Wednesday night, September 22, at Cobo Hall.

The Delegates on Tuesday night will select seven district Councilors, Delegates to the AMA, a President-Elect, a Speaker and a Vice-Speaker.

* * *

The official opening of the Centennial Exhibits and Scientific Session at 11 a.m., Tuesday, September 21, at Cobo Hall, will be a gay affair. In addition to welcoming addresses, there will be band music and the presentations of many flags. Presidents of the Senior Medical Classes and Presidents of the SAMA groups from both medical schools will participate. Who will cut the ribbon?

* * *

Col. John A. (Shorty) Powers will come from Houston to speak at the Centennial Banquet, September 22, at Cobo Hall. He was selected to give the annual Biddle Lecture by MSMS President Oliver B. McGillicuddy, M.D.

Well known as the "Voice of the Astronauts" during the first manned space flights, the energetic Shorty now is a space education consultant.

The Reception and Banquet will be fun with dancing, good food, installation of the new president, and a tribute to living MSMS past presidents.

* * *

"Organized Medicine—To What Purpose?" is the provocative topic chosen by Reginald D. Atkinson, M.D., Waterloo, Ontario, Canada, for his remarks to the House of Delegates at the Sheraton-Cadillac, Tuesday night, September 21. Some of his comments will deal with the Canadian Developments in Hospital and Medical Services Insurance.

* * *

The alumni association of medical schools across the nation have expressed keen interest in the Centennial—and many will provide special social functions for their graduates in Michigan.

The following notes may not be complete because new events are being reported almost every day.

For example, alumni from the following universities will be seated at special tables at the MSMS Century Luncheon at Cobo Hall, Tuesday, September 21: New York, Marquette, Louisville, Cornell, Georgetown. Also on Tuesday, there will be a luncheon for the University of Buffalo; open house for Wayne State University from 4 to 6; and open house for University of Michigan from 5 to 7. There will be receptions and dinners Tuesday, for Boston, Columbia, Illinois, Jefferson, Pennsylvania, Yale, Western Ontario, Washington and the Detroit Club of Alpha Kappa Kappa.

* * *

While MSMS members observe their Centennial, members of the Blackwell No. 20 Branch of the American Medical Women's Association will celebrate their Golden Anniversary. Members will meet at special tables during the MSMS Centennial Banquet Wednesday night, September 22.

* * *

A much-sought-after speaker, Charles E. Berry, M.D., Houston, will address the Medicine and Government Day morning program on Friday, September 24. Doctor Berry is medical director for the Manned Space Craft Center, National Aeronautics and Space Administration. Americans always keenly await his evaluation of the astronauts after their grueling flights.

Telling the Story

The MSMS publication about Doctor Beaumont recently was distributed to the 1,000 scientists attending the Annual Meeting of the American Society of Animal Science at Michigan State University.

The Society purchased the booklets from MSMS and provided them to the geneticists, nutritionists, physiologists, food scientists and other related specialists.

* * *

The Michigan Association of the Professions plans a presentation to MSMS during the Cultural Center Dinner, Thursday night, September 23, at the Rackham Building. The presentation will be made by Adrian N. Langius, F.A.I.A., president now of MAP. MAP members will be in attendance.

* * *

Reservation forms for the Centennial meal functions and special events have been mailed to each MSMS member. Orders were sought in advance to assure good accommodations.

However, tickets for luncheons and/or dinner meetings may be purchased at the MSMS Registration Desk in Hall C of Cobo Hall during the Centennial.

* * *

Michigan Blue Shield-Blue Cross has invited physicians and medical assistants to visit the Blue Shield headquarters between 2 and 4 p.m., September 22. The visitors will see the computer center, teletype area and claims division.

* * *

Attention is called to the fact that the Medicine and Religion Convocation on Sunday, September 19, will begin at 2:30, rather than 3:00 p.m., which was publicized earlier. A fine musical interlude of organ music will begin at 2:30 with Miss Yvonne Miller of Detroit.

Another musical highlight of the convocation will be selections by the outstanding A. C. Spark Plug Division General Motors Choir, from Flint.

* * *

"The Doctor Collects Art" show will be on view at the Detroit Institute of Arts during the MSMS Centennial in Detroit, September 19-24. The special exhibition open to the public, has been arranged by the Arts Commission of the city of Detroit and the Trustees of the Founders Society, Detroit Institute of Arts. The show will continue through October 3.

List Clinic Speakers For Battle Creek

Medical authorities from seven states and Michigan have accepted invitations to speak November 4 at the annual Southwestern Michigan Clinic Day at Battle Creek Country Club. Bertram Zheutlin, M.D., Clinic Day chairman, reports the following speakers and topics:

Wolf Zuelzer, M.D., Children's Hospital, Detroit, "Autoimmune Hemolytic Anemia."

Allan C. Barnes, M.D., Johns Hopkins Hospital, "The Role of the Obstetrician in the Prevention of Congenital Defects."

Denton Cooley, M.D., Texas Medical Center, Houston, "Surgical Treatment of Coronary Artery Disease."

William Dameshek, M.D., New England Center Hospital, Boston, "Autoimmunity and Leukemia."

Robert A. Good, M.D., University of Minnesota, "Immunologic Deficiency States."

Robert Greenblatt, M.D., Medical College of Georgia, "The Suppression of Ovulation in the Management of Gynecologic Disorders and Family Spacing."

Frank H. Mayfield, M.D., University of Cincinnati, "Russell L. Mustard Lecture."

L. G. Goodrich Dies Unexpectedly

A national leader in the health care field, L. Gordon Goodrich, 59, died July 26, at his home in Birmingham. He was a former executive director of Michigan Blue Shield and at the time of his death special assistant to the president of Michigan Blue Cross. A native of St. Johns, Michigan, where he was born on May 16, 1906, Mr. Goodrich was graduated from the University of Detroit and later was president of the University of Detroit Alumni Club. A former insurance executive, he joined Michigan Blue Cross in 1942 as assistant director, but was called two months later to serve as a Navy lieutenant. When he returned to Detroit in 1946, he was named assistant director of Michigan Blue Shield. He became executive director in 1959. In 1946 he was appointed special assistant to William S. McNary, president of Michigan Blue Cross.

Among his contributions to the field of medicine and health was his service as treasurer of the Michigan Health Council.

U-M Lists PG Courses

The Department of Postgraduate Medicine of the University of Michigan School of Medicine announces that the following courses will be given on a short continuous basis:

Blood Coagulation Assay Techniques—April 4 through 8.

Blood, Diseases of the—February 14 through 18.

Electrocardiographic Diagnosis—March 28 through April 1.

Endocrinology and Metabolism—April 18 through 22.

Heart, Diseases of the—February 28 through March 4.

Immunology, Clinical — March 21 through 23.

Nuclear Medicine—February 7 through 9.

Nuclear Medicine — One-month training course.

Obstetrics and Gynecology—January 19 (afternoon) through 21.

Ophthalmology Conference—April 18 through 20.

Otorhinolaryngology Conference—April 14 through 16.

Otorhinolaryngology for Generalists—December 2 through 4.

Pediatrics—January 17 through 19.

Physical Medicine for the Clinician—November 18 and 19.

Physiology—January 10 through 14.

Psychiatry—January 19 through 21.

Pulmonary Diseases — April 1 through 13.

Radiology of the Chest—March 28 through 30.

Renal Disease, Hypertension and Vascular Disease — January 31 through February 4.

Rheumatology — March 23 through 25.

Therapeutics, Recent Advances in—April 25 through 29.

* * *

THE FOLLOWING four courses are designed for the resident physicians in the affiliated hospitals who are preparing for board examination:

Anatomy (Surgical)—January 17 through February 25.

Anatomy (Obstetric and Gynecologic) — February 28 through March 11.

Pathology—October 4 through December 17.

Pathology (Obstetric and Gynecologic)—March 14 through 25.

* * *

THE FOLLOWING courses will be given on an intermittent basis:

Anatomy—Thursday afternoons, January 20 through May 5.

Electrocardiography & Heart Disease — Tuesday evenings, September 7 through December 7.

Internal Medicine, Clinical — Thursday afternoons, September 2 through December 16.

Internal Medicine, Clinical — Wednesday afternoons, September 29 through December 22 or January 5 through April 6 (Both courses to be held at Wayne County General Hospital.)

Internal Medicine, Selected Clinical Topics in—Tuesday evenings, January 4 through April 12.

Psychiatry for Internists—Wednesday afternoons, February 16 through May 4.

Summer Off-Campus Program—Date to be announced early in 1966.

WSU Calendar Coming

Representatives of the Wayne State University School of Medicine reported on August 16 that the fall PG calendar would be provided for publication in the October issue of MICHIGAN MEDICINE.

GOVERNOR ROMNEY CHALLENGES PHYSICIANS "TO ACCEPT ADDITIONAL RESPONSIBILITIES"

Congratulations to the Michigan State Medical Society on a Century of Service.

Those who have built this nation always exhibited a profound faith that today's dreams could become tomorrow's realities.

Nowhere have the miracles been any more astounding than in your field of medical science. More progress has been made in medicine in the last 25 years than in the preceding 20 centuries.

Our nation's basic concepts have been equally miraculous. Concepts and practices of religious, political, social and economic freedom that are unequalled anywhere else on earth.

One of the great things about our country is that the American Miracle has never stopped. No aspect of our national life is yet what it should be. But our system can be improved without limit, which is one evidence of its inspired origin.

And you have the responsibility, through the application of your special talents and abilities to make it better. For like it or not you wear the mantle of special leadership, opportunity and responsibility.

You are members of a healing profession and your lives are dedicated to binding up the wounds of the diseased, afflicted and suffering.

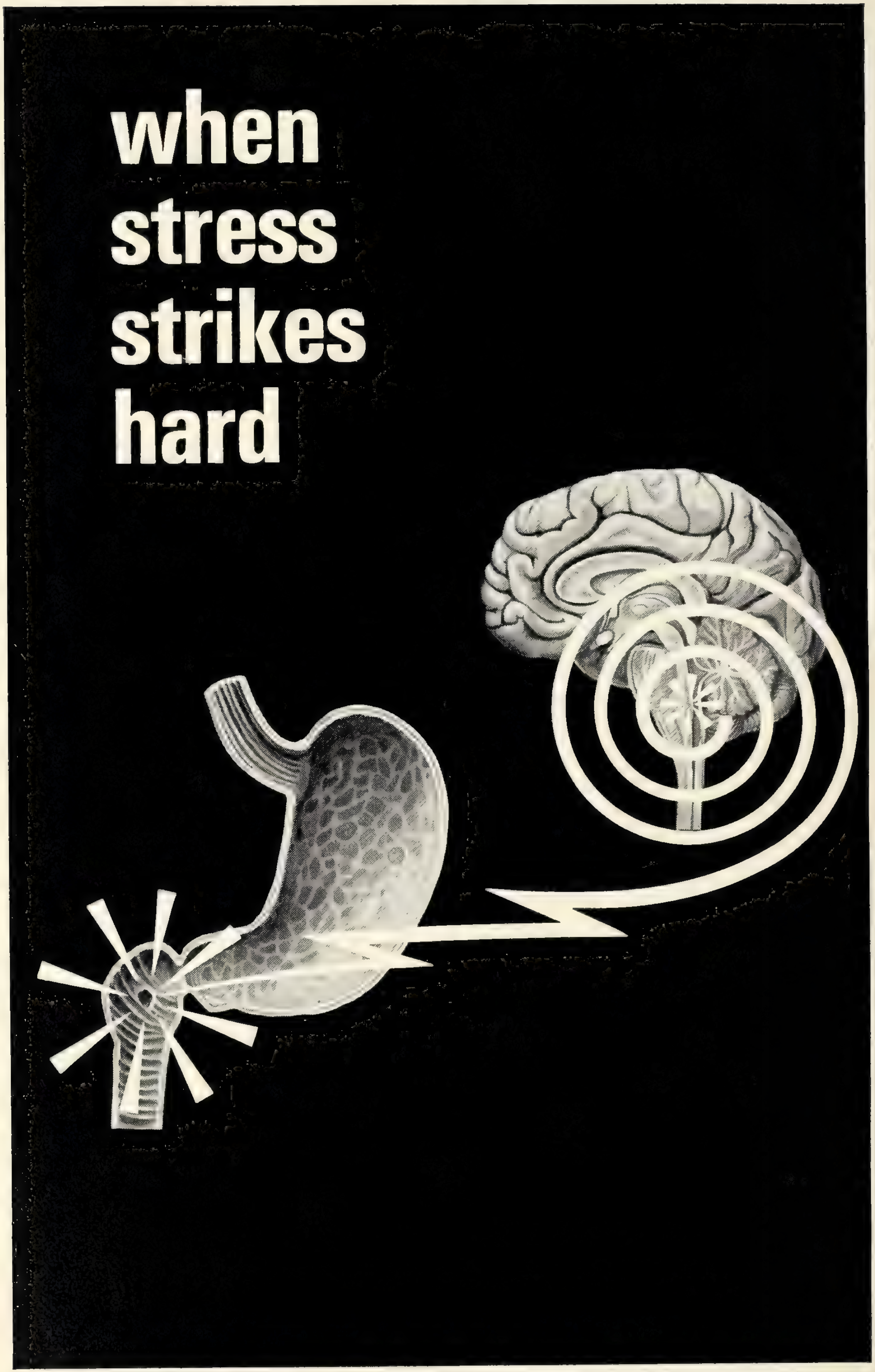
But you are much more than that. Because of the honor and esteem which men bestow upon you, because of the significant achievement your medical degree and experience represents, you are in a unique position to bind up the wounds of a strife-filled world.

I am certain that you will progress in the next 100 years. And I pray that you will see fit to accept these additional responsibilities.

Sincerely,

George Romney

THE GREAT SEAL OF THE STATE OF MICHIGAN
A.D. MDCCCXXXV.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Peptic Ulcer • Pylorospasm
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Pro-Banthīne, as expected, reliably moderates excesses of gastric secretion and gastrointestinal motility.

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Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur with Pro-Banthīne (propantheline bromide) and it is contraindicated in the presence of glaucoma or severe cardiac disease.

With Dartal (thiopropazate dihydrochloride) extrapyramidal and parasympatholytic symptoms have been reported and, rarely, leukopenia, erythematous skin reaction and allergic purpura. Do not administer to patients under the influence of alcohol, barbiturates or narcotics and use cautiously with sedatives, in epileptic or depressed patients or in those with liver damage. Reactions typical of phenothiazines may occur.
Dosage: One tablet three times a day.

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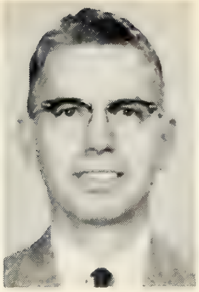
Research in the Service of Medicine



STATE HEALTH COMMISSIONER:

SALUTE TO MEDICINE

By ALBERT E. HEUSTIS, M.D., M.P.H.
STATE HEALTH COMMISSIONER
LANSING

As Michigan's State Health Commissioner, on the occasion of this Centennial, I take pleasure in saluting the Michigan State Medical Society for all its past accomplishments in coping with human disease for the past century. And, I look forward with you to even greater accomplishments in the protection of the health of the people of the state in the years ahead.

Fortunately, Michigan has been blessed with a history of constructive and cooperative effort between its physicians in private practice and its state government.

* * *

THE STATE HEALTH department owes its very existence to the dedicated efforts of early members of your Society, and one of the health department's cardinal principles has always been the involvement of private physicians throughout the state. This pattern of involvement is now being followed by the mental health department as well.

The successful results of this cooperative endeavor in reducing the incidence of human diseases are matters of public record. These results have come about not through the efforts of governmental health services alone or through the efforts of private practicing physicians alone, but through the mutual cooperation of both elements plus the support of the people at large, who have acted both legislatively and personally to advance health matters in our state.

This working-together of public and private interests in Michigan—this cooperation between private organized medicine and governmental health services

. . . has made simple goitre a rarity through the use of iodized salt.

. . . has achieved an outstanding system of blood banking through the voluntary inspection program of the health department, and has provided an array of blood fractions that is the envy of other states by the use of outdated blood and material from human placentas.

. . . has prevented disabling rheumatic heart disease complications through the distribution and use of antibiotic materials, and through the excellent diagnostic services now available from state and private laboratories.

. . . has brought about such constructive legislation as the school immunization and tuberculin check-point law—state assistance with community mental health centers—the recently enacted legislation requiring each county in the state, either alone or with its neighbors to participate in a local health department—and the state's gradual assumption over the years of a greater share of the cost involved in the care of crippled and afflicted children.

. . . has improved case finding in venereal diseases through the confidential reporting of positive laboratory tests and will do the same for tuberculosis with the confidential reporting of suspicious x-ray findings.

. . . has provided for greater safety in childbirth and for the control of birth defects through PKU testing and through the determination of adequate Rh incompatibility and through the promotion and provision of adequate prenatal care and participation in an impartial review of the deaths of all mothers and newborn babies, which assists in the recognition of problems and helps to chart the improvement of future care in these areas.

. . . has helped our state, through its Crippled Children Commission, to have a child amputee center second to none in the entire country.

In the years ahead I look to the continuation of this excellent pattern of public-private cooperation between organized medicine and governmental health services to make the federal system of health services for the elderly and for children function also in a manner that results both in the provision of the care needed by the patient and in the provision of satisfaction to the members of a profession dedicated to service of the highest quality.

HOW DIFFERENT WERE THINGS A CENTURY AGO?

By JOHN R. G. GOSLING, M.D.,
ASSISTANT DEAN, SCHOOL OF MEDICINE
UNIVERSITY OF MICHIGAN
ANN ARBOR

The Civil War was over, the land in a turmoil and the future uncertain. The shock of the assassination of a president who had become a national hero was recent and profound.

Just how different were things a century ago?

It is certainly almost a tradition by now to prepare such a retrospective examination and point out either earth-shaking changes or startling similarities—and as in most periods of history, either approach is possible, but neither will really tell the tale.

Before me I have a small volume which purports to be the opening record of the Michigan State Medical Society. Resident members could join for an initiation fee of $2 and by signing the Constitution and Bylaws. (That, at least, is different.) There were four standing committees, vis., Executive, Finance, Publication, and Medical Ethics, and 15 members constituted a quorum of the Society.

Perhaps characteristically it became necessary almost immediately to create some working committees, including Medical Hygiene, Vital Statistics, Surgery, Practice of Medicine, Obstetrics, Zymotic Diseases, Epidemics, and To Examine and Decide upon Voluntary Contributions for Presentation to the Society. Several were never heard from again.

At the annual meeting a year later, the first scientific discussion was directed to a paper, "Notes on a Species of Fungus Growing upon the Nesaea Verticillata," which examined the possible role of the fungus in causing abortion in various domestic animals. If this seems a trifle incongruous as an opening, you must recognize one of the major differences.

Perhaps an extract from some pharmacology (Materia Medica) notes of the day might help:

Collecting and Preserving of Vegetables

> *Vegetables are to be collected in dry weather—annually—and are not to be kept beyond a year.*
>
> *Roots and rootstocks are to be dug up when the old leaves and stalks have fallen and before new ones have appeared.*
>
> *Barks ought to be collected in that season in which they can most easily be separated from the wood beneath.*
>
> *Flowers are to be gathered when newly blown and fruits and seeds when ripe.*
>
> *Herbs and leaves are to be gathered after the flowers are blown but before the seeds have ripened.*

There is a great deal more on detailed preparation and preservation but I think the idea comes through. The important point is that the plant preparations were dominant.

THE CHEMOTHERAPEUTIC materials were still over the horizon. Chloral hydrate to produce sleep would be introduced as a drug in 1869. Salicylic acid was noted to lower body temperature in fever in 1875 but aspirin was not introduced until 1899, with barbiturates and procaine making their appearance in the decade that opened the Twentieth Century.

A century ago the medicinal properties of a variety of plants were a matter of some considerable significance and a paper on the subject quite in keeping, as is the one to follow it on Gelsemium (yellow jasmine or woodbine) which is a "fine gentle and sovereign remedy." The "botanical" approach to medicine made homeopathy less a paradox than it seems today. It was some years later that A. J. Clark calculated that the highly effective "thirtieth potency" of the homeopathic schedule represented one molecule of the drug in question in a sphere with a circumference equal

AUTHOR
John R. G. Gosling, M.D.

A Civil War surgical instrument set used by a physician with the army of Stonewall Jackson

to the orbit of the planet Neptune.

This is not to imply for a moment that the disciples of Hahnemann were not a subject of some imitation. At the 1868 annual meeting, note was taken of creating a Professor of Homeopathy in the Department of Medicine. A resolution followed citing the action as an "opprobrious indignity upon the Medical Faculty" by proclaiming that "a wild theory, an insane hypothesis and a proved imposition, because successful in point of number of its apologists and patrons, is entitled to the same consideration and official recognition as legitimate science." There was a good deal more said but it had no more visible effect than the heifer, filled with croton oil and tethered in the homeopathic lecture room by the medical students of the next generation, was to have on the course of homeopathic instruction.

* * *

OF INTEREST, too, was the concern expressed about registration of marriages, births and deaths. The statute enacted by the legislature was in need of strengthening and enforcement and its merit and importance were clearly recognized and strongly supported by the Society.

All of this and much more characterized the concern of Michigan physicians a century ago. At this time, their medical school, The University of Michigan, had been operating for 15 years.

To obtain an M.D. degree then one had to study for three years with a recognized practitioner of medicine and during this period attend two courses of lectures, the last of these, at least, at Michigan, though the first could be at some other reputable medical institution. The course of lectures in 1865 opened on the first of October and continued until the last week in March with four lectures each day. The candidate for the degree must declare himself at the opening of the term, must be 21 years of age, have studied practical anatomy, have written a thesis on a medical topic in English, French, German, or Latin, and must pass an examination by the faculty at the end of the term.

In 1865, 70 men met these requirements, an increase from 51 in 1864 and 39 in 1863, but a small proportion of the 417 men who enrolled in the lectures of that year. The large total enrollment represents in part men who would obtain degrees somewhere else less demanding in examination and thesis, but its primary components may well have been men who hastened into medical service in the Civil War and now desired to polish up a bit in regular fashion.

* * *

IN POINT OF fact, medical knowledge and standards of medical training were changing rapidly. The American giants were Oliver Wendell Holmes who was a respected Harvard anatomist; Austin Flint, who had recently published his *Practical Treatise on Diseases of the Heart* and would shortly publish *Principles and Practice of Medicine;* and John C. Warren who had done the first surgery under anesthesia at Harvard. James Marion Sims was on a tour of Europe having published his monumental work almost 13 years before. William Beaumont had died a decade earlier.

The great advances of the decade were primarily European. Claude Bernard had already produced the bulk of his work but Brown Sequard, Robitansky, Helmholtz, Henle, and Rudolf Virchow bulked very large in the medicine of that time. Virchow's *Cellular Pathology* had been published in America a few years earlier but his work on tumors was released in 1865-66. Mendel's work was published in 1866 and Semmelweiss died that year.

Darwin's *Origin of the Species* was brand new and Paget was at the peak of his career in England; James Young Simpson was a senior and respected obstetrician and Joseph Lister was a rising young surgeon. It was in March of 1865 that he first employed carbolic acid in surgery, though his publication did not come until two years later. Pasteur, in 1864, had begun the work leading to pasteurization of wine, and his work with anthrax was still years in the future. Robert Koch was in his final year of study at Gottingen with a tour of military service and several years of uninspired country practice before him. The European influence on American Medicine was still predominantly English and French but the tremendous burst of German academic achievement was to alter that completely in the decade to come.

The growth of the next generation was hardly predictable. Roentgen was just entering the University of Utrecht and Osler was a high school boy in Canada. William Welch was 15 years old; Walter Reed, 14; and Halstead, 13. Paul Ehrlich was 11 and Howard Kelly, 7 years of age. There was a good deal still to be done, and excitement

The author writes, "Society presidents were expressing the same concerns, committees were examining the same problems . . ."

was expressed about the rapidly expanding body of medical knowledge.

At the sixteenth annual meeting of The American Medical Association, in Boston, on June 6 to 9, 1865, suitable patriotic sentiments were the pattern of the day. The Michigan delegation of seven represented men from Harper Hospital, Michigan Asylum for the Insane, Northeastern Detroit Medical and Scientific Association, and The University of Michigan. Seventy-one permanent members from Michigan appear on the 1865 rolls, with 30 communities represented. At the meeting they heard a review of the use of Sulphites of lime and soda in treating Zymotic Diseases (gangrene, erysipelas, phlebitis, etc.). The concept was that Sulphurous acid was released in the system preventing fermentation or decomposition of the blood, and a number of cases were cited to support the contention. An elaborate presentation on the problem of insanity in women is well worth reading, and the problem of smallpox and vaccination was still a subject for elaborate and heated discussion. Surgical procedures for cleft palate were discussed and treatment of chronic inflammation of the joints by setons, incisions, and immobilization was advocated. A new and particularly interesting presentation covered the medical topography and epidemics of California—still largely unfamiliar territory to the vast majority of the members.

In passing, one also notes that the report of the Committee on Medical Education rates The University of Michigan first in total number of Medical School Matriculants (417) but only fifth in number of degree.

* * *

IN ALL, THE tenor of the communications and conversations of the day was not unlike our own.

Society presidents were expressing the same concerns, committees were examining the same problems in more elementary stages—and if the physician of the day didn't have rubber gloves, or hammers, or antibiotics or diuretics—he didn't really feel the lack because he didn't feel concern about antiseptic surgery or bacteriostasis or hormone deficiencies or renal function in the sense we do today.

We begin with a smile for the "old timer" in all his innocence but it may have a wry aspect to it when we stop to reflect upon our own relationship to the future.

It would be well to keep a sense of perspective and a sense of humor.

A retrospective glance of this sort may help in both respects.

PROPOSE PRESERVING OLD HARPER HOSPITAL

Harper Hospital is the only hospital on the list of 46 of the "best in Detroit's historic buildings," which were recently part of a photographic exhibit at the Detroit Historical Museum.

The recent display was timely because there are three Detroit organizations which in the past 18 months have intensified their efforts to preserve historic sites. Playing major roles in such a project are the Detroit Historical Commission's Committee on Historic Preservation, the Detroit chapter of the American Institute of Architects and the Detroit Heritage Photography Workshop.

The Detroit News ran the complete list of the 46 "untouchable" buildings on July 4. A copy of the list may be obtained from the MSMS headquarters by any interested physician.

Harper Hospital was incorporated on March 20, 1863, and the first barracks-like buildings were completed on October 12, 1864.

Harper observed its Centennial in 1963 with many special events in Detroit.

AMA Promotes Nation's Health In Countless Ways

**By WM. A. HYLAND, M.D.,
CHAIRMAN, MSMS DELEGATION
TO AMA HOUSE OF DELEGATES,
GRAND RAPIDS**

The American Medical Association at present with over 206,000 members was organized by a small band of interested physicians in Philadelphia in 1847 for the purpose of promoting the science and art of medicine and the improvement of public health.

At the first meeting physicians came on foot, horseback, carriage, boat and train. This was an organizational meeting to prepare for future sessions, committees were formed, election of leaders and discussants on various subjects were appointed, rules were made and the order of business was prepared for a meeting the following year (1848) in Baltimore.

At the latter meeting the first formal officers were elected and a House of verified seated delegates held sessions; in addition, scientific sessions were held which dealt with pertinent medical subjects.

THIS ORGANIZATION gradually increased in size as the country grew. Today we have a House of over 230 representatives from states, insular professions and over two dozen sections and government services. The American Medical Association is essentially a federation of state and territorial medical societies.

The House of Delegates holds an annual meeting in June and a clinical session late in the fall. Scientific and economic problems that are new and others that have been studied are presented and discussed on both occasions.

When the AMA House of Delegates sits in session twice a year, Michigan is represented by seven delegates, elected by the MSMS House of Delegates, and by Michigan doctors representing AMA sections.

THE AUTHOR
Wm. A. Hyland, M.D.

Special sessions are rare but are held whenever necessary; February, 1965, and January, 1953, were the last that were called.

All business and scientific meetings are open to the public and press.

ALL THE RESOLUTIONS and most of the subjects are thoroughly discussed by the reference committees, necessitating very little general discussion on the floor of the House. Mainly questions of clarification and amendments agreed upon subjects are brought up on the floor. Very occasionally a minority report is brought out of the reference committee meeting to the floor of the House when the debate or discussion has been difficult and a diversified opinion has resulted.

The subjects before the House are well thought out and discussed, avoiding any haste or conclusions that might be embarrassing later on.

Between sessions of the House, the American Medical Association is represented by a Board of Trustees, whose members serve a term of three years, with no trustee elected for more than three terms. There are 12 in number who with the addition of the President, President-elect, immediate Past President and Executive Vice President, form the Board. These members are elected by the House and perform the responsibilities of the House when it is not in session. The Speaker and Vice Speaker of the House who are its officers attend all meetings of the Board of Trustees.

The House also elects members to four committees, namely, Council on Constitution and Bylaws, Judicial Council, Council on Medical Education and Council on Medical Service.

Frequently the Speaker is directed by the House to appoint special committees. The length and extent of the subject covered is specified at the time of appointment, with the privilege of extension if the work is not completed in the alloted time.

The Board also appoints committees to augment the work of the House; various scientific studies are covered in these committees, including practical questions such as nursing, nutrition, mental health, food and drug, tobacco and smoking research.

All these committees and councils, totaling over 100, have nearly eight members of the American Medical Association serving on them.

THE MAIN purpose of the AMA is the improvement of the health of the people, improvement of medical education, dissemination of medical knowledge and advancement of the code of ethics. This is in addition to the economic side of medicine which has become so important in recent years. The American Medical Association is extremely interested in encouraging young people to enter the profession and has provided a large educational fund to help educate qualified applicants. More recently the American Medical Association is lending aid to those interested in nursing education.

A recent image of the association as a tremendous lobby interest, spending millions for such, is so greatly exaggerated that one really disdains to mention it other than to absolutely deny the accusations of dramatic headline seekers, who look no farther than the wild statement.

THE AMERICAN Medical Association is a vast source of information for every practitioner, whether he is general or specialist. True, the specialty societies are excellent for scientific information but they need the American Medical Association to cover all scientific as well as socio-economic questions—which, fortunately, the American Medical Association does in great detail.

Well over half of the American Medical Association budget is spent in scientific activity.

Members of Congress are continually calling upon the American Medical Association for scientific information that is necessary in discussing medical matters in legislation. This occupies a far greater portion of our Washington office than most of the members realize.

All members of the American Medical Association receive four publications of scientific and socio-economic nature from the organization as dues-paying members. In addition, the AMA publishes dozens and dozens of treatises on scientific subjects which are available to all members. Even for the public the American Medical Association goes to great effort to keep all advised through "Todays Health."

Research being done by the University of Michigan School of Medicine, and supported by an AMA-ERF grant, is discussed by Maurice H. Seevers, M.D., Ph.D., center, with Doctors Tomoji Yanagita and Gerald Deneau. The research probes the effects of pure nicotine on Rhesus monkeys, and was described in the July 1965 issue of TODAY'S HEALTH.

The American Medical Association is the originator of the phrase "Lifetime Learning," for those in the profession as well as those about to enter. This is part of the total and permanent education of the physician. The Board of Trustees, with the Council on Medical Education and the post-graduate program, realize that geographical location and pressures of practice handicap further studies for many members of the profession. They have urged state and county societies to bring all possible education to the busy man by stimulating postgraduate study and discussion in local areas.

THROUGH NECESSITY the research program has not yet reached the level hoped for by the association, but has recently been greatly enhanced by the establishment of the Bio-medical Research Department. This research center will add greatly to the scientific aspect of the organization.

The American Medical Association is the leader for all members and organizations in the profession. It is a beacon light necessary for the public and the profession both in this rapidly changing scientific world.

The public, as well as the profession, is becoming more and more dependent on the American Medical Association than ever before—and they should.

AMERICAN PUBLIC EXPECTS PHYSICIANS TO ASSUME HEALTH LEADERSHIP —— AMA DOES THAT, AND WELL

ONE HUNDRED YEARS AGO AND HENCE

Dean Calls Attention to Some of the Similarities Between Medicine Today And a Century Ago . . .

**By WILLIAM N. HUBBARD, JR., M.D.
DEAN, SCHOOL OF MEDICINE
UNIVERSITY OF MICHIGAN
ANN ARBOR**

In 1865, medicine was being revolutionized by the rapid development of new knowledge from research laboratories, by the impact of a great war and by a rapidly expanding economy which left the people the means for purchasing medical care at a rate unknown in earlier years. The influence of Jacksonian democracy and its emphasis on individualism was in conflict with a developing public concern with availability of health services.

The physician of 1865 was overwhelmed by the variety of medications available on the market and recommended in the literature. Although extravagant claims were frequently made for the effectiveness of various preparations, they were rarely supported by other than personal observations of their utility by individual practitioners. Drugs were not standardized as to effectiveness and many drugs were dangerous to the patient.

In retrospect, it is possible to say that none of the agents used in that time had a specific curative effect on any disease. It was, however, a time when an unprecedented quantity and variety of drugs were administered on physicians' orders as well as on the initiative of the patient. A good deal of harm was done by this relatively uncritical use of drugs.

Twenty years before, Oliver Wendell Holmes in Boston and Semmelweis in Austro-Hungary had emphasized the importance of antisepsis in puerperal fever and had, through their studies, identified it as a contagious disease usually spread by those caring for the mother during childbirth. Shortly thereafter, Lister applied and popularized this same concern with antisepsis in the conduct of surgical procedures. Louis Pasteur was at the height of his scientific accomplishments and was laying the foundation of scientific microbiology. A young man named Koch was 22 years old in 1865 and just beginning his efforts in applying the observations of Pasteur to human disease.

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Rokitansky and Virchow were 60 and 45 years old, respectively; each of them having contributed to the establishment of the new science of cellular pathology. Through their efforts an objective appraisal was possible of the relationship between tissue changes and clinical disorders.

* * *

In the year 1865, Claude Bernard published his "Introduction to the Study of Experimental Medicine." In this he carried forward to the patient the teachings of his preceptor Magendie who had laid in France the foundations of experimental physiology.

In 1865, all but a few of the physicians practicing in Michigan had been trained through a perceptorial program in which they associated themselves for varying periods of time with an established doctor.

At that time the only medical school in the state was in Ann Arbor at the University of Michigan. It was then 15 years old, being the second faculty organized by the new university. Abram Sager, who had been the original President of the Faculty of Medicine from 1850 to 1851, presided as dean.

He originally held the title of Professor of Zoology and Botany, but subsequently relinquished that title to assume the first post of Professor of Obstetrics and Diseases of Women and Children. It was the custom in those days for the deanship to be rotated from time to time, so that between 1850 and 1868, Sager was dean for 10 years. In the first 40 years of the new medical school's history, six men occupied the deanship while in the next

The rich history of education, research and service by the School of Medicine at the University of Michigan had many of its beginnings in this original medical school building on the Ann Arbor campus.

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40 years only two men—Victor Vaughan and Hugh Cabot—served the post.

* * *

Medical schools in those days, as at present, were expected to provide only part of the total education of the physician. The catalog of 1865 notes that the student must "have evidence of having pursued the study of Medicine and Surgery with some respectable Practitioner of Medicine for three years (including lecture terms); must have attended two full courses of lectures, the last of which must have been in the college of Medicine and Surgery of The University of Michigan and the previous one in this or some other respectable medical institution."

A total of 600 to 700 hours of lecture were offered at the rate of four lectures per day to complete a single course. Students were examined each day on the prior day's lecture in order to ensure their comprehension. Actual clinics were offered two times weekly at which "operations performed gratuitously to the patient in the presence of the class" were available.

There were six members of the faculty and one anatomical demonstrator in 1865. They were confronted with a rapidly rising number of medical students and 425 students were registered that year. Although only 32 degrees were offered in 1865, the demand for additional doctors rapidly pushed the number to 160 three years later.

By 1869 the catalog noted for the first time that "a well arranged hospital is available on the university grounds under the charge of the Medical Faculty and open to patients resorting to the university for treatment." It was further noted that this hospital "affords the student the advantages of clinical instruction." That same year there was some evidence of tension between the development of medical education in the state and the state legislature when it was noted in the catalog that "the statute requiring, as a condition of receiving appropriations, that a Professor of Homeopathy be appointed in the Medical Department had been repealed."

Seven years later, a College of Homeopathy was established at the university and continued for 43 years.

* * *

Within a short time after 1865, Michigan began to share with other portions of the country a remarkable expansion in the number of medical schools.

Between 1868 and 1888, ten new schools offering the M.D. degree were founded in Michigan, of which only the Detroit Medical College founded in 1868 survives.

In 1885, this College merged with the Michigan College of Medicine and through a series of changes in title and sponsorship became the forerunner of the Wayne State University Medical School.

Colleges of medicine had a brief life in Lansing, Saginaw, Battle Creek and Grand Rapids as well as Detroit. Colleges of homeopathic medicine rose and fell in Detroit, Lansing and Ann Arbor.

By the time of the Flexner Report in 1910, only three medical schools existed in the state. These were the Detroit College of Medicine, The University of Michigan Medical School and the American Medical Missionary College in Battle Creek. The latter was in its last year of existence at the time of the Flexner Study. By then the state was inundated by a large and poorly accounted number of people setting themselves forth as physicians.

The differences of the medicine of today from that of 100 years ago have been fully accounted in this Centennial issue.

* * *

Let me call attention to some of the similarities.

It would take a brave and even arrogant mind to suggest that the scientific contributions of our decade have a fundamental significance to medicine that equals the importance of the contributions of Rudolph Virchow, Claude Bernard, Louis Pasteur, Semmelweis, Koch and Lister. In their day, the importance of their findings was fully recognized. In avoiding the pitfall of overweening pride, it is well to compare the significance of the concepts developed in our generation with those of 100 years ago.

The over-use of drugs in the management of problems of health and disease by both patients and their physicians is one of the urgent problems of our present generation.

The increasingly potent compounds that we use

From the archives of the University of Michigan School of Medicine is this picture of the Class of 1865-66.

today carry harmful effects no less threatening than the emetics and purgatives of an earlier time.

The problem still remains of a conflict between the individual observations of the practicing physician and the critique of experimental medicine in evaluating the appropriateness of mixtures of drugs as well as individual agents.

* * *

A restless and expanding society impatient with the apparent inability of established medical schools to meet the quantitative demand for physicians appears ready to embark 20 years after the Second World War on the kind of uncritical expansion of medical education that occurred 20 years after the Civil War.

This state's legislature appears prepared to grant licensing privileges for the practice of medicine to all who claim the right regardless of their educational background. It is important to recall that although New Jersey initiated the first state licensure examinations in 1772, by 1850 most states had abandoned them altogether in the wake of the Jacksonian democracy that demanded individual freedom of enterprise and the abolition of any restrictions by government. It was not until 1895 that almost every state had reinstituted an examination board.

In a democracy, those who argue for standards of excellence must always expect to be accused of abusing the principle of equality of opportunity. On the other hand, to fail to meet the quantitative need of society for a service is to threaten extinction.

A kind of 'Gresham's Law' operates in medicine too where poor quality will drive out high quality if both are allowed to compete in an open market on supposedly equal terms. The shortage of high quality physicians may soon force into existence a great volume of poorly educated ones.

There are even a few who would protect the present medical schools from the responsibility of expanded numbers by encouraging the development of schools in circumstances where the intellectual environment and clinical opportunities are short of the best available.

* * *

No one has the wisdom to foretell the future. From the past 100 years, however, it can be asserted with fair assurance that the science of medicine will continue to evolve and that the increases in knowledge will continue to change radically the content of medical practice.

The physician for the last 100 years has been primarily concerned with the internal milieu of the patient and the manipulation of the events within the body. These efforts continue to demand increasing specialization to the point that the role of the generalist must now be consciously preserved.

There is nothing to inhibit the specialist from assuming the responsibilities of a physician of first contact and continuing concern, but it is not likely that he will assume this role unless he intends it. Whether the most efficient and effective utilization of the time of the specialist is to have him serve this role is one of the questions to be answered by the future.

The patient himself looks upon his anxieties and distress as a part of his total life pattern.

As burdens of illness in the community are less and less likely to be dealt with in episodic fashion with definitive therapy, the role of the family health advisor which was the major activity of the physician until after the turn of this century will again increase in importance.

The organization for distribution of medical services has always been a function of the society in which time and culture placed it.

The role of the professional continues ultimately to be the servant of society. In part, he achieves his role by being a leader, but he must ultimately be servant.

The humanistic traditions of medicine and their dedication to improving the health of mankind while alleviating his suffering will stand for the next 100 years as a guiding central theme. Both science and the society that supports it will affect the mode of expressing this professional responsibility.

* * *

Maintaining the traditions of our profession is not a simple task today any more than it was 100 years ago or will be 100 years from now.

Whether medicine survives as a learned and respected profession will depend in large part upon the degree to which we dedicate ourselves, our science and our art to the welfare of others.

Looking Ahead:

–PEOPLE LOOK MORE TO HOSPITAL FOR HEALTH CARE
–CHANGES COMING IN CARE OF AMBULATORY PATIENTS
–RESEARCH LEADS TO CHANGES IN PATIENT CARE
–STRIKING THERAPEUTIC CHANGES AHEAD

**By ERNEST D. GARDNER, M.D., DEAN,
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WAYNE STATE UNIVERSITY
DETROIT**

Observance of the Michigan State Medical Society's first 100 years is a welcome and opportune occasion to view the possibilities for medical progress during the next century. I approach this effort with considerable trepidation, full of the recognition that the segment of medicine for which I have genuine responsibility is limited to the medical school, and, by customary association, to its teaching hospitals.

Although I am a basic scientist by training, I shall direct my comments to the impact of teaching hospitals upon the clinical fields of medicine.

This is certainly not a consequence of any thought concerning the relative importance of either the basic sciences or clinical medicine, for it is certain that the growth of the basic science research program has been responsible in many ways for the extension of clinical knowledge since World War II.

* * *

THIS CO-OPERATIVE relationship is a matter for concern at some other occasion, less important, perhaps, than that which we celebrate this month.

It should be noted, however, that the major changes in patient care since the war have resulted directly from the research effort—both basic science and clinical—that is characteristic of the modern university teaching hospital complex.

Today, one readily accepts the inevitable progression: research creates new approaches to the disease process; this in turn creates the need for curricular changes; this ultimately leads to new specialties and orientations.

Concurrently, there has been a significant and far-reaching change in patient expectation. Growth of health insurance pre-payment plans, along with an unexcelled prosperity and new federal legislation, has led our citizenry to expect a quality of health care never conceived before.

* * *

IN SUMMARY, MORE and more people look to the hospital for health care. While our current insurance procedures favor inpatient facilities, it

seems likely in the future that patient expectations and actuary experience will bring about a dramatic transformation. Hospital outpatient clinics will be called upon with increasing frequency for the management of ambulatory health problems.

In programs where outpatient treatment is encouraged, only one hospital bed per 500 insured patients will be required, while each of these 500 patients may be expected to make four clinic visits annually.

The focus of university planning for teaching material will shift from the exotic and traumatic to the ambulatory patient. Outpatient cases may well pre-empt the chronically ill as prime teaching material. In the long run, this will permit more

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Ernest D. Gardner, M.D.

and more patients to carry on "normal" lives, avoid the psychological decompensation associated with prolonged hospitalization, and allow health insurance companies to effect long-range economies of benefit to all consumers.

* * *

TO IMPLEMENT these changes, however, tomorrow's teaching hospitals will have to be reorganized along well-charted lines. Ambulatory patients will have to be regarded as "private" in the sense that they will be seen on an appointive basis in pleasant surroundings. They may be retained in "observational" status for a brief period without entering the hospital proper. Families may be required to provide some of the hospital nursing and custodial care for temporary patients. Such facilities for limited care can be expected to become *de rigeur* in the next 25 years.

Change will likewise affect inpatient care. Increased numbers of patients can be expected to be either critically ill or hospitalized for major surgery. More geriatric cases can be anticipated. For all patients hospitalized in the teaching hospital, there will be a shoring of both psychological and technological dams; telemetry for monitoring and computers for storing case material will be paralleled by the development of supporting teams operative in the areas of social problems and psychological medicine. Patients will no longer be discharged into pathogenic social environments, and "half-way houses" may well become part of the expected recovery regimen.

* * *

SIMILARLY, WE CAN anticipate the most striking therapeutic changes. Organ transplantation will become commonplace, hyperbaric chambers will revolutionize major surgical procedures, and intensive care units will be the order of the day in teaching centers.

As the utility of these procedures and apparatus becomes clear, they will be replaced by fruits of research as yet untested. One does not expect the nature of teaching centers to change. They will continue to be the places where new ideas are generated and novel approaches to the solution of problems are fostered.

Recalls Doctor Bohn's Service at Seney

(As MSMS observes its Centennial, Michigan physicians will enjoy reading about the experiences of Frank P. Bohn, M.D., who served the community of Seney in the Upper Peninsula during the lumber boom of the 1890's. Doctor Bohn, who died in 1944, served as U. S. Congressman from the 11th District from 1927 to 1933. The following account of Doctor Bohn's work at Seney is quoted from "Holy Old Mackinaw," a natural history of the American Lumberjack, by Stewart H. Holbrook, Macmillan, 1956.)

"Doctor Frank P. Bohn, fresh from medical college, arrived in Seney late in 1890 to be the town's first doctor. They needed a doctor in Seney.

"On my first Christmas day there," Dr. Bohn recalls, "I worked all day and all night treating the fighters who could find their way to my office by following the red trail on the snow that reddened and broadened as the day wore on.

"I doubt there was anywhere another town like Seney as it was in the nineties. I have seen the streets and the broad sidewalks of the town literally swamped with fighting loggers. . . . The Marquis of Queensberry would have been shocked. When a man was down his opponent jumped upon him with both feet, kicking and tearing at him with the cruel calks in his shoes. Yet no man interfered. There was no use. Until a man realized he had been beaten, it was best to let them continue.

"The ill fame of Seney's saloons and crude houses of prostitution grew in time to attract the notice of the *Police Gazette*, then in its heyday. The lively journal sent a man to Seney to look things over, and the correspondent did so nice a job that even today the legend of the Seney Stockades will not down, but appeared only recently in one of Hollywood's many epics of the timber.

"The *Gazette* man wrote, and the *Gazette's* wondrous artists illustrated, a story to the effect that in Seney were two vast houses of sin; that dozens of heretofore pure girls had been enticed therein; and that they were kept there, virtually prisoners and against their will, by big, high, peaked stockades, such as were used to protect forts in Indian days.

"The story was sheer invention in the best *Gazette* tradition. I was in Seney many years, and nothing like stockades ever came under my observation.

"Seney was bad enough without stockades. Ears were chewed off there regularly. Loggers' smallpox was prevalent, and diseases not mentioned in the public prints of the day abounded. As competition in venery increased the boss sports took to shooting at each other. One night Dr. Bohn was called to attend Dan Dunne, wounded and bleeding from a gunshot, in his own saloon; and at almost the same time he was called to patch up Steve Harcourt, one of the "opposition." Dunne lived—that time. Harcourt died. Dunne swore out a warrant for arrest of the two remaining Harcourts. In custody of an officer on the way to jail at Manistique, they encountered Dunne at Trout Lake. As Dunne came out a door, one of the Harcourts pulled a gun and fired. Dunne fell dead.

"Seney's great days were passing."

The Medical Society, The Universities And Medical Care

A Suggestion for Collaborative Planning

By ANDREW D. HUNT, JR., M.D.
DEAN, COLLEGE OF HUMAN MEDICINE
MICHIGAN STATE UNIVERSITY
EAST LANSING

A newcomer to Michigan is inevitably impressed with the excellence in which its history of medicine is nurtured. In medical practice, research, education, and administration, Michigan contributions have been of the highest quality.

This fine record has surely been abetted by the collaborative and mutually supportive roles played by the medical schools and the Michigan State Medical Society.

The much reiterated town-gown dichotomy, which in an extreme state could be seriously damaging both to patients and the medical profession, seems to be minimal in Michigan. Faculty members are active in the House of Delegates, and work effectively with practicing members of the Society on committees in fields such as continuing education. Indeed a considerable leadership role in the affairs of the State Medical Society is carried by people in academic medicine.

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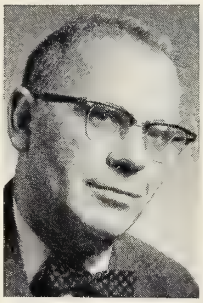
MICHIGAN, IN common with the rest of the nation, now faces a manpower crisis. One phase of this crisis is that represented by about 140 communities which have filed their need for physicians with the Michigan Health Council.



THE AUTHOR
Andrew D. Hunt, Jr., M.D.

These requests, usually for general practitioners, could provide the impetus for joint concern by the State Medical Society and the universities. Various alternatives for meeting these communities' health needs could be explored. These deliberations could help shape educational goals within the medical schools, and define graduate training programs geared for community medicine in Michigan.

A study of this nature would encompass not only the parameter of community health served by medical practitioners, but also that being met by agencies such as health departments and community mental health clinics. Shortages of physicians appropriately trained for agency positions are increasingly severe, and a quantitative and qualitative estimate of the situation would be most helpful to the medical schools in their quest for guidance in direction for their educational programs.

* * *

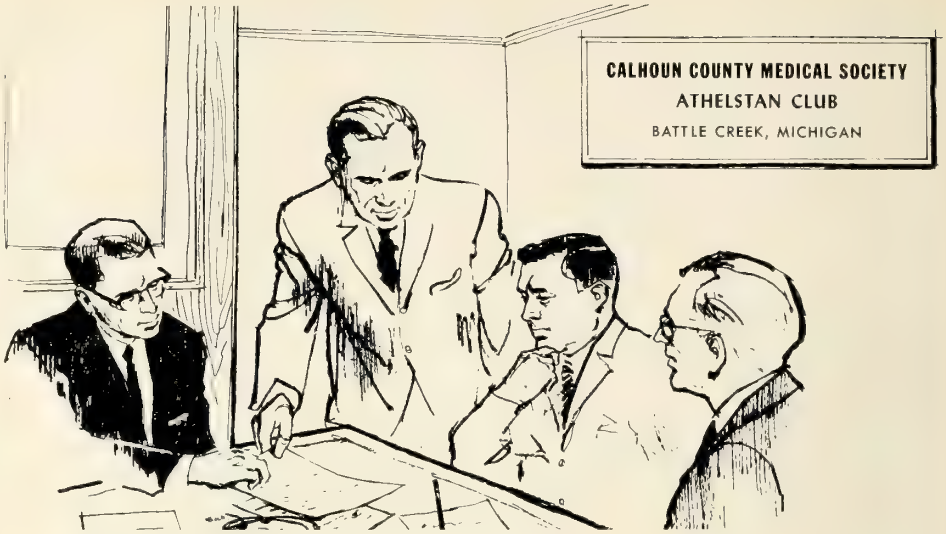
SUCH A STUDY, taking into account projected increments in effective demand for medical services brought about by such factors as increases in population and gross national product, impact of education on sophistication of demands for care, and current and future social legislation, could provide the basis for an ongoing relationship between the universities, the Medical Society, and the people of Michigan.

Such a relationship could expand Michigan's tradition of collaboration between the universities and both the state and county societies to an active program to meet society's changing needs for medical care.

Without some such joint effort, continued unmet community needs can lead only to ad hoc efforts to relieve shortages, often unsoundly conceived and proprietary in sponsorship.

Michigan's distinguished history both in medicine and education would seem to be a strong guarantee that such a course will not be followed.

"A few determined dedicated doctors discuss, search, argue—conceive a visionary scheme — PREPAYMENT in 1931. They were such men as Doctors Harry F. Becker, Wilfred Haughey, Joseph E. Rosenfeld, F. C. Winslow and Harvey C. Hansen." So states the booklet, "This Is the Story of Blue Shield, An Exciting Michigan Story."



Ambitious Goal Of 25 Years Ago A Reality Today

**By SIDNEY ADLER, M.D., PRESIDENT
MICHIGAN MEDICAL SERVICE
DETROIT**

Physicians of Michigan founded Michigan Medical Service 25 years ago in the firm belief they could cushion the cost of catastrophic illness through voluntary prepayment health insurance.

It was a concept born in the depths of the economic depression at a time when both physicians and patient realized the need to spread cost of medical care, and the Federal Government was preparing to socialize medical services.

Today this ambitious goal is a reality. What started as a very limited scope of benefits for low income groups has now been expanded to almost every economic level.

Our benefits have been extended to almost every aspect of medicine, and the public has endorsed this contribution by physicians by making Michigan Medical Service the third largest voluntary prepayment health plan in the nation.

THE AUTHOR
Sidney Adler, M.D.

Medicine made these giant strides by recognizing that medical and socio-economic problems are part of our social organization; that medical care is no longer a privilege but a right of every citizen.

Let us recall Henry E. Sigerist's* words that the physician's environment can no longer be one of isolation; the patient must be taken into account: that the relationship must be one seeking and the other giving "health."

Medicine, he said, is and must remain on a person-to-person basis because it is the keystone of the healing arts.

As we look to the future, Professor Sigerist's lessons take on added significance. A new society has developed—highly industrialized and highly specialized. The organism is more and more complex.

We must consider that shifts in population from rural to urban have made medicine more impersonal and that, with modern highways, the trend is increasing.

We must consider that population increases, more doctors and more hospital beds, plus the new techniques of treatment and rising costs, presage a medical era of incalculable importance.

We must consider the increasing governmental demand for "womb-to-tomb" medicine, subsidies

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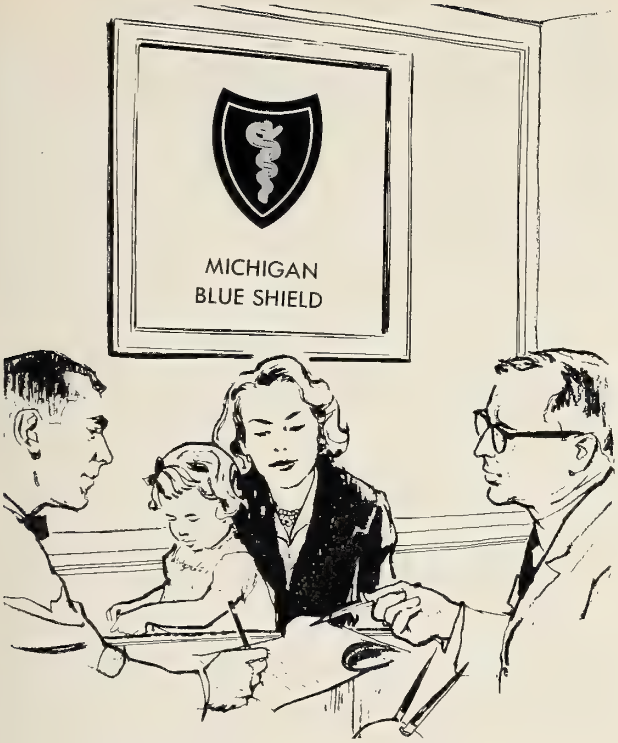
*Henry E. Sigerist, M.D., who died in 1957, formerly was director of the Institute of the History of Medicine at the University of Leipzig and then later Director of the Institute of the History of Medicine, John Hopkins University.



Michigan Medical Service opened for business March 1, 1940 and the first family signed a contract. "Thus a new era of medical care is born for the peoples of Michigan," the Blue Shield booklet declares.

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for the low income and the aged, and the grim fact that it is no longer the question of ability to pay but willingness to pay by the public.

That future is tied to a marked increase in the scope of benefits to include mental illness, pre and post-natal care, nursing homes, rehabilitation centers. It is tied to home and office visits, drugs, emergency room, dispensary and clinic medicine, because CHA and hospital group practice experiments are already with us.

Above all, it is indelibly likened to how best can we serve the patient, because he is the keystone for quality of care.

> **We know—and we all agree—society must fight disease and provide medical care for the whole population, because man has a right to health, cost and economic status notwithstanding.**

We know, too, that the physician has a right and a willingness to provide this care without roadblocks from well intentioned but unrealistic social planners.

The mechanism best to serve both could and should be Michigan Medical Service. The record of the past 25 years proves this.

VIEWS ON THE PROGRESS OF MEDICINE

**By WM. S. McNARY, PRESIDENT
MICHIGAN HOSPITAL SERVICE
DETROIT**

Here in Michigan and elsewhere, accelerating change in medical research and practice during the past century has overshadowed the 2,400-year history of medicine since Hippocrates.

Rapid developments are a familiar part of our society as the public calls for far-reaching and immediate adjustments in every phase of our complex political and economic structures.

It should not be surprising to us, then, that the public has asked government to review its relationship to them regarding health care. As government moves closer to the day when it will become the major purchaser of health care on behalf of many Americans, our nation's economic sectors, both private and public, will be required to draw upon their unique ability to work together effectively to meet the demands put upon them.

Blue Cross, long a catalyst in the provider-purchaser hospital care relationship, expects to take on new dimensions. This will be especially true where the quantity of health care sought may seem to conflict with the availability of quality care at a cost which can be supported by the current economy—public and private. Modern medicine, too, will have an even greater obligation and opportunity to express its point of view and to see to it that Americans receive the best that the medical sciences can offer.

We all expect that the next century will see startling new medical advances. Unprecedented numbers of Americans will have the opportunity to take advantage of them. I am certain that the proven leadership of Michigan's doctors and hospitals and the experience of Michigan Blue Cross as an interpreter of the needs of both the providers and purchasers of health care are assets we shall use successfully to meet the challenges which face the health care field in the future.

THE AUTHOR
Wm. S. McNary

Yesterday and Tomorrow in Psychiatry

BY ROBERT A. KIMMICH, M.D.
DIRECTOR, MICHIGAN DEPARTMENT
OF MENTAL HEALTH
LANSING

The past 100 years have seen the development of most of what we now know as psychiatric services, both for the mentally ill and the mentally retarded. The field of medicine has provided most of the leadership and professional guidance of these programs, although many lay persons and professionals from other disciplines have brought pressure and skills into the movement.

The private practice of psychiatry in this country began increasing rapidly after the turn of the century and was essentially a European import. Additional surges forward took place after both World Wars.

* * *

A PRIMARILY ORGANIC point of view gradually gave place to one where the intra-psychic and social causes of mental illness were more clearly understood and responded to in practice. The interest in organic and microchemical abnormalities in mental disorders has continued to be a subject which is extensively investigated.

Various chemical and physiological treatments have had their place, with the latest developments being the energizing and tranquilizing drugs, which have to a considerable degree supplanted many of the former methods, including the classical sedatives.

Psychiatric hospitals have improved, both in their physical and therapeutic aspects, including the development of a therapeutic social milieu within the hospital. Outpatient facilities for adults and children have mushroomed throughout the country and various psychotherapeutic methods have been applied with reasonable success. As experience, research and training increased in the field, public understanding also improved with a resulting decrease in the severe stigma surrounding mental disorders. A considerable reluctance to seek psychiatric treatment still exists.

THE AUTHOR
Robert A. Kimmich, M.D.

* * *

MORE AND MORE MONEY has gone into mental health services, and public psychiatric programs have grown rapidly in recent years. More service has been given more quickly to many more persons. Interest in treatment and prevention of mental retardation has also rapidly increased. Preventive methods in the total field are slowly becoming known, although primary prevention is such a broad problem that it is still in its technical infancy.

The next century will undoubtedly bring changes in the psychiatric field beyond our ability to forecast. It would seem, however, that certain trends may give us clues.

Future problems to be dealt with will include those associated with the larger number of elderly persons living in our communities in relative health, but without employment. Psychiatric problems associated with extremely rapid travel, including travel in space, may include reactions to personal and social isolation, time and space disorientation, and possibly disorders relating to changes in the physical environment.

Further research will probably decrease the number of mentally retarded persons, because of improved knowledge and control of prenatal and genetic influences.

* * *

THE ROLE OF psychiatrists will continue to evolve as will probably that of all physicians in the direction of more social involvement in economic and regional planning and more active consultation at various levels in the government and the community.

Early and widespread counseling of persons regarding psychiatric problems will develop and will be done by many persons outside of the field of medicine, as well as within, thus allowing concentration of psychiatry on core problems. It may be that the annual mental examination will be as common as the regular physical examination!

* * *

PSYCHIATRIC PRACTICE will be involved to a greater extent with psychosomatic syndromes such as heart disease, hypertension, gastro-intestinal difficulties and many other serious disabling physical disorders. Also, shorter term treatment methods may be further developed with the psychiatrist giving leadership in this area, but concentrating his own practice on the most severe disorders. Psychoanalysis will probably still be an effective method for research and for the treatment of specific difficulties, as well as further refining of personality theory.

An increase in the therapeutic focus on the total family can be expected, as well as in home care and less long-term hospital care.

Psychiatric hospitals will probably evolve into small intensive treatment centers, where research and training are also done, but where the current practice of housing many socially disabled persons will be discontinued.

Pharmaceutical preparations can be expected to improve in their ability to alleviate a larger number of mental and emotional symptoms with greater specificity. The involvement of many persons outside the medical field in mental health work will continue to increase, with psychiatrists devoting much time to research and training in this area. Further studies will heighten their ability to evaluate psychiatric treatment methods and results, thereby advancing the field and also creating economy in the use of personnel.

The psychiatric field may enter more usefully into studies regarding the psychodynamics of social change, with the development of international law encouraging wider development of standards and of application of psychiatric knowledge to the field of politics and the maintenance of peace.

* * *

IF THERE IS a prolonged period of relative world peace, more national funds will be available for education in all its aspects and the improvement of public services, including mental health, welfare, public health and the problems surrounding delinquency of adults and children. Mobilization of funds for the improvement of general living conditions could be expected to result in the primary prevention of many mental disorders, thereby reducing the need for as much treatment of disease.

Major changes will be made in medical education and among them will be improved preparation of physicians in the psychosocial aspects of disease and in techniques for their alleviation. They will probably also receive a significant education in general social problems, and in their roles as community leaders beyond the confines of their medical practices.

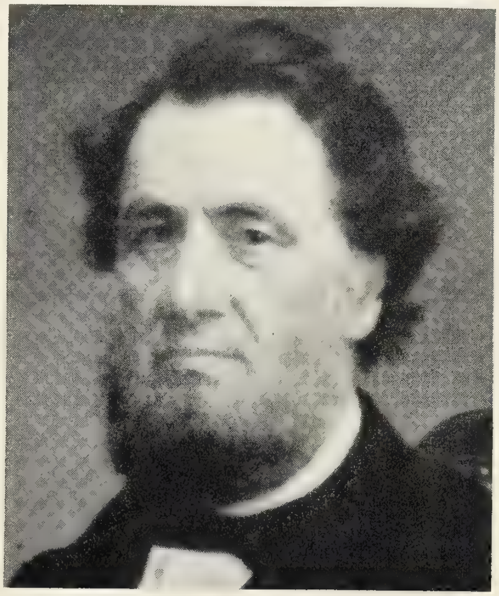
Many different kinds of prepaid or tax-supported health plans and services will allow everyone early availability of psychiatric services.

* * *

EVERY INDIVIDUAL will probably receive an identifying code number at birth which will allow fairly accurate epidemiological studies of the general population through electronic data processing. It would thus be possible to follow any specific individual through various services and life crises and to plan more specifically for unduplicated services and expenditures.

Followup studies could be done which would bring us much closer to knowing where to focus our efforts in prevention, treatment and education.

The crystal ball has grown dim and there are many unrecognizable shapes, one of which seems to indicate that a greatly increased amount of leisure time in our country may also bring with it problems for the psychiatrist.



GOVERNOR
100 YEARS AGO

Henry H. Crapo, the fourteenth governor of Michigan, was born in Dartmouth, Massachusetts, May 24, 1804. He received his education in that state, and took up his residence in New Bedford, where he remained for many years.

Mr. Crapo moved to Michigan in 1857 and settled in the village of Flint. He soon became extensively interested in the manufacture and sale of lumber and did much to promote the growth of his adopted city by encouraging its manufacturing interests.

He served the city of Flint as mayor for some time, and was elected governor in 1864. He served in that capacity two terms until the close of 1867.

Governor Crapo died at his home, in Flint, July 23, 1869.

(Taken from "History of Michigan" by C. R. Tuttle, published 1873 by Tyler & Co., Detroit.)

MICHIGAN GAVE FOUR PRESIDENTS TO THE AMA

Four distinguished Michigan physicians have served as presidents of the American Medical Association. They were:

Zina Pitcher, M.D., 1856
William Brodie, M.D., 1886
Donald MacLean, M.D., 1895
Victor C. Vaughan, M.D., 1914

Following are brief stories about these four leaders, the material excerpted from the publication "A History of The American Medical Association, 1847-1947," by Morris Fishbein, M.D., published in 1947.

* * *

Zina Pitcher M.D., 1856

Zina Pitcher, M.D., the tenth president of the AMA, was a pioneer physician in Detroit, mayor of Detroit and a member of the University of Michigan Board of Regents.

He was born in Washington County, New York, April 12, 1797. His father died when he was five years old. His mother appreciated the value of an education so that Zina received a good academic education. At the age of 21, he was able to begin the study of medicine under a private practitioner with whom he spent four years, attending during the time two courses of lectures at the Castleton School of Medicine in Vermont. In 1822 he received the degree of Doctor of Medicine from Middlebury College, Vermont.

He soon obtained an appointment as assistant surgeon, U. S. Army, from President Monroe, and during the administration of President Andrew Jackson he was promoted to the rank of surgeon. After 15 years of army service, he began the practice of medicine in Detroit in 1836 and soon took a deep interest in the organization of her educational institutions.

As a Regent of the University from 1837 to 1852 he had a prominent part in the founding of the medical department at Ann Arbor. When the first medical faculty was appointed, his name was listed as Emeritus professor.

One of the principal achievements was the establishment of free public schools in Detroit.

He was three times chosen mayor of Detroit.

Doctor Pitcher was attending physician of St. Mary's Hospital and surgeon of the U. S. Marine Hospital in Detroit, a member of the City Board of Health, and associate editor of the Peninsular Medical Journal. He was president of the Michigan Territorial Medical Society during 14 years; president of the earlier Michigan State Medical Society, 1855-56; a founder of the Sydenham Society of Michigan and a founder and president of the Detroit Medical Society. He was president of the AMA in 1856.

He died in Detroit, April 5, 1872, at the age of 75 years.

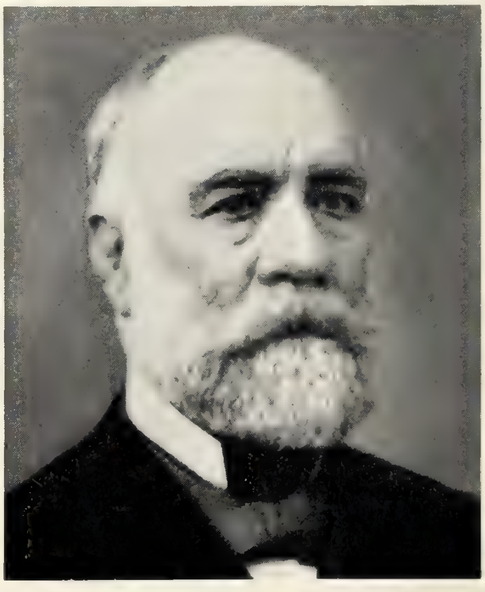
* * *

William Brodie, M.D., 1886

William Brodie, M.D., the 38th President of the AMA, was long active in the AMA, The Michigan State Medical Society and The Wayne County Medical Society.

He was an Englishman by birth, having been born at Fawley Court July 26, 1823, coming to

ZINA PITCHER, M.D.



WILLIAM BRODIE, M.D.

New York State, near Rochester, in 1832. Here he received his general education, and after moving his residence to the new state of Michigan, be became interested in medicine in 1847, as a student of William Wilson, M.D., of Pontiac. He attended his first course of medical lectures at Birkshire Medical College at Pittsfield, Mass., the second at Vermont Medical College at Woodstock. He completed his medical studies at the College of Physicians and Surgeons, Columbia College, New York City, receiving the degree Doctor of Medicine in 1850.

He began the practice of medicine in Detroit and soon became active in medical society organization. In 1852 he was one of the founders of the Detroit Medical Society, and its president in 1855.

The Michigan State Medical Society elected Doctor Brodie its president in 1876, and the same year he was chosen president of the Wayne County Medical Society, which position he held continuously for 12 years.

Throughout the Civil War he served as surgeon of the First Regiment of Michigan Volunteers. For a number of years he was Professor of Clinical Medicine in the old Michigan College of Medicine. From 1880 to 1885 he was the editor of the Therapeutic Gazette.

Doctor Brodie attended his first meeting of the AMA in 1855, and was a faithful attendant in the following 30 years. In 1857 he served as one of the secretaries, and in 1875 as first vice president of the Association. His presidential address in 1886 gave special emphasis of the need of uniform and elevated standards of requirements for the degree of Doctor of Medicine.

Doctor Brodie died in Detroit July 30, 1890, at 67 years of age.

* * *

Donald MacLean, M.D., 1895

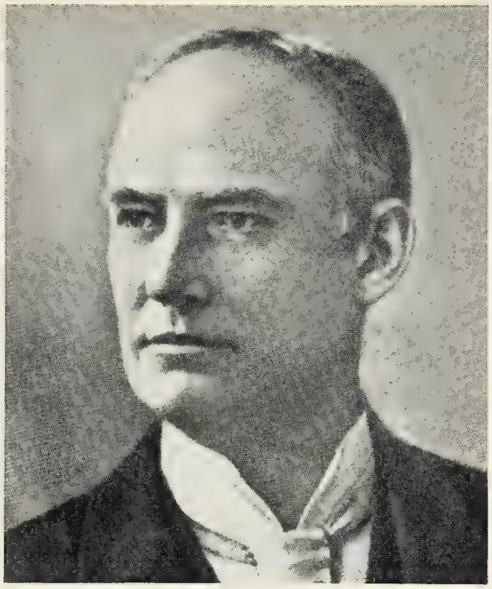
Donald MacLean, M.D. , the distinguished Michigan surgeon and professor at the University of Michigan Medical School, was president of the AMA in 1895.

He was of Canadian birth, having been born in Seymour, Ontario, December 4, 1839. After graduation from Queens University, Kingston, Ontario, he taught in a country school, and in 1858 he went to study medicine at the University of Edinburgh. In 1862 he graduated from the University of Edinburgh with the degrees M.B., C.M. and Lic. R.C.S. Edin. He was appointed House Surgeon at the famous Royal Infirmary.

Soon after his return to Canada in 1863, he was appointed assistant surgeon of the U. S. Army and served for one year in General Army hospitals in St. Louis, Louisville and Harrisburg, Pennsylvania.

In 1864 he was appointed Professor of Clinical Surgery at the Royal College of Physicians and Surgeons, Kingston, Ontario.

In 1872 when 33 years of age, he received the appointment of professor of surgery in the College of Medicine, University of Michigan. He soon gained the highest recognition as a teacher of clinical surgery and a bold and skillful operator.



DONALD MACLEAN, M.D.

After 17 years of teaching at Ann Arbor, he resigned and located in Detroit, where he soon acquired a large consulting and surgical practice. He become surgeon-in-chief of the Michigan Central and Grand Trunk Railway systems.

In 1884 he served as president of the Michigan State Medical Society, and in 1887 as president of the Detroit Library Association.

In 1893, Queens University conferred on him the honorary degree of LL.D.

He died in Detroit July 23, 1903, at the age of 63 years.

* * *

Victor C. Vaughan, M.D., 1914

Victor C. Vaughan, M.D., who served with distinction on the University of Michigan Medical faculty 45 years, was president of the AMA in 1914.

His birthplace was Mount Ayr, Randolph County, Missouri, October 27, 1851. At the age of 19 he was professor of Latin at Mount Pleasant College, Huntsville, Missouri. In 1874 he entered the University of Michigan to pursue his chemical studies, and a year later added the degree of M.S. to that of B.S. obtained in Missouri. In 1876 he received the degree of Doctor of Philosophy, and two years later that of Doctor of Medicine.

As early as 1875 Doctor Vaughan became associated with the medical school of the University of Michigan as instructor in medical chemistry. In 1878 he published a textbook on physiological chemistry which passed through three editions. In 1880 he was made assistant professor, and in 1883, full Professor of Physiological and Pathological Chemistry, and Associate Professor of Therapeutics and Materia Medica. He was the first to

VICTOR C. VAUGHAN, M.D.

hold a chair of physiological chemistry in a medical school in this country, and to give chemical instruction from this point of view.

His first contribution from the chemical laboratory in 1875 was on the separation of arsenic from other metals. Throughout the succeeding years the study of organic and inorganic poisons held great interest for him.

Doctor Vaughan was a pioneer in public health in Michigan and for 30 years was a member of the Michigan State Board of Health.

In 1889 the new hygienic laboratory was opened at the University of Michigan, and Doctor Vaughan served as director for 20 years, and published many papers with F. G. Novy, M.D., Henry F. Vaughan, M.D., and George T. Palmer.

His service with the University of Michigan Medical School covered a period of 45 years as teacher and administrator. From 1891 to 1921, he served as dean of the medical faculty.

During the First World War, Doctor Vaughan was assigned to duty as head of the communicable disease section in the Surgeon General's office. He was awarded the Distinguished Service Medal, "for his meritorious and conspicuous service."

His service with the American Medical Association covered a period of a quarter of a century in many capacities. He was a member of the House of Delegates from 1902 to 1906; in 1904 he was chairman of the Reference Committee on Medical Education, which recommended the formation of the Council on Medical Education, and of which he was a member from 1904 to 1913. After serving as president of the Association, he became chairman of the Council on Health and Public Instruction from 1919 to 1923.

He also served as president of the American Association of Physicians in 1908. He died at the home of his son, Dr. Warren T. Vaughan, in Richmond, Virginia, November 21, 1929.

Michigan Physician Served 12 Years as AMA Speaker

In addition to the four physicians from Michigan who served as AMA Presidents, Frederick Cook Warnshuis, M.D., of Michigan, served for 12 years as Speaker of the AMA House of Delegates.

Doctor Warnshuis also contributed much to MSMS as secretary and editor.

The AMA Journal on January 19, 1946, carried the following obituary about Doctor Warnshuis:

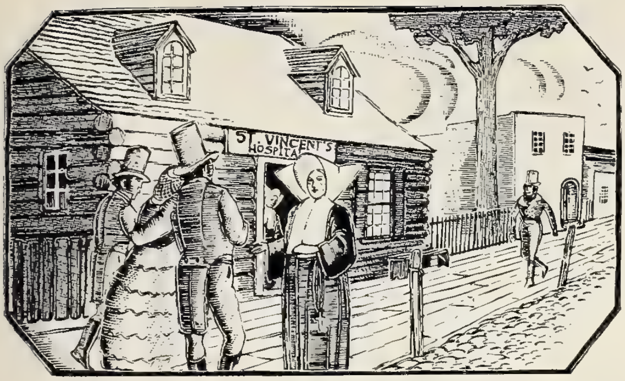
"Doctor Warnshuis was born in Alton, Iowa, June 16, 1880. He graduated at Hope College, Holland, Michigan, and took his degree at the Grand Rapids Medical College in 1902. Doctor Warnshuis had served as president and secretary of the Kent County Medical Society and as secretary of the Michigan state board of medical registration. He was named secretary of the Michigan State Medical Society in 1913, becoming editor of its journal a few years later. In 1934 he resigned both positions to join the California Medical Association as secretary-treasurer and director of public relations. In 1938 he became president of the newly organized American Medico-Legal Association and editor-in-chief of its journal, with headquarters in Boston. In 1941 he went to the American Consulate in Windsor as acting assistant surgeon, U. S. Public Health Service.

"His service with the American Medical Association included membership in the House of Delegates in 1913-1914, 1916, 1918 and from 1920 to 1934. He was Vice Speaker of the House from 1920 to 1922 and Speaker from 1922 to 1934.

"During World War I, Doctor Warnshuis was chief and later commanding officer of the Surgical Service, Base Hospital Number 99, American Expeditionary Forces.

"He died January 7, 1946, at his home in Windsor, Ontario.

FREDERICK COOK WARNSHUIS, M.D.



First Hospital Established 120 Years Ago . . .

The site of the "first hospital in Michigan" was marked by the J. L. Hudson Company in 1926 when the civic-minded retail firm erected 20 historical markers in Detroit.

At the time, J. L. Hudson printed a small booklet, "Historical Detroit—A Story in Bronze," and carried these general comments:

"It is hoped that this (series of tablets) is only the beginning of a movement that will awaken a renewed appreciation of the colorful and romantic story of Detroit and of the courageous men and women whose efforts laid the foundation for this great city." Since 1926, the J. L. Hudson Company has placed historical markers in its continuing concern about history.

Following is the short story in the Hudson booklet about the first hospital in Michigan—120 years ago:

> "First Hospital in Michigan
>
> "This is St. Vincent's Hospital, a log house that stood on the southwest corner of Larned and Randolph Streets. It was opened for the treatment of the sick by four Sisters of Charity, on June 9, 1845, and was instrumental in the prevention of the unnatural ravages of many of the dreaded diseases.
>
> "In 1833 four Sisters of Clare, who came from Bruges, Belgium, to Pittsburgh, and thence to Detroit, occupied the corner house for their dwelling and opened the adjoining building as a school for boys and girls. They were soon succeeded by four Sisters of Charity, who continued the school, which was styled "St. Vincent's Academy."
>
> "Noting the inadequate facilities at times of epidemic diseases the Sisters of Charity remodeled the interior of their home building on the corner and opened it as a hospital, which they named St. Vincent's.
>
> "Into what were lately the environs of business Detroit, fine buildings were thrusting themselves, and down-at-the-heel streets are recovering their ancient dignity and importance. This corner is witness to that truth. Today, Detroit's hospitals are removed from this area; they are great buildings, with hundreds of trained nurses, and with beds for many thousands of patients."

* * *

The first hospital also was marked by Galicia Caravan, No. 77, Order of Alhambra, Detroit, with a bronze plaque on the Detroit Hospital.

Following is the wording on that plaque:

> "First hospital in Northwest Territory, Detroit Memorial Hospital opened originally in 1845 as St. Vincent's Hospital by the Daughters of Charity of St. Vincent DePaul, later named St. Mary's in 1850. Held for over a century and directed by the Sisters, it was the first hospital in the Northwest territory, the first shelter for the insane, the first military hospital and free clinic in Michigan, second in the United States. Purchased in 1949 by the Detroit Memorial Hospital Corporation. This corporation preceded by Galicia Caravan No. 77, Order of the Alhambra, Detroit, Michigan, October, 1959."

Physicians Asked to Help Restore Post Hospital

Interest in Michigan medical history, with the MSMS Centennial, is probably at an all-time high—and what an ideal time for the Mackinac Island State Park Commission to ask for help in restoring the old Fort Mackinac Post Hospital. William Beaumont, M.D., treated Alexis St. Martin there in 1822.

The commission offers the photograph shown at the bottom to help visualize the needs. Physicians with medical instruments, beds, cabinets, tables, etc., that were particularly used in army hospitals in the late 19th century, are asked to write to Eugene T. Peterson, Director of Historic Projects, Mackinac Island State Park Commission, Box 523, Mackinac Island, Michigan.

DETROIT 1865

CEDAR BLOCKS REPLACE STREETS OF COBBLESTONES

To help MSMS members visualize Detroit 100 years ago when MSMS was organized, Michigan Medicine presents the following excerpts from "History of Detroit" by Harriet A. Marsh and Florence A. Marsh, published in 1935 by Lakeside Press, Chicago.

The following comments from the chapter "Detroit in the Sixties" vividly illustrate life in Detroit . . .

"Indians were still seen on the streets in their blankets. The squaws carried papooses or large packs of Indian baskets on their backs. However, the town was rapidly losing its frontier air. Politics was being much talked about. Since the founders of the new Republican party were largely Detroit men, an enormous gathering was held with torchlight parades, preceding the election of Abraham Lincoln.

* * *

"RETAIL MERCHANTS were starting to make Woodward, north of Jefferson Avenue, a street for the retail trade. G. and R. McMillan built their store at the corner of Woodward Avenue and Fort Street. This company has the reputation of being the oldest retail firm in the city. It is now located on Second Boulevard at Bethune Avenue.

"A number of new churches were built, among them the one for the Shaarey Zedek Jewish Society, and another on Washington Boulevard for the Westminster Presbyterian Church, later to be used by the parish of St. Aloysius. The House of Correction was completed, and we had the satisfaction of seeing a real postoffice building at the corner of Griswold and Larned streets.

"The need of streetcars was much discussed, and in 1862 the city passed an ordinance to build the lines. On May 12, 1863, a company was incorporated and on August 1, a group of city officials took the first ride on the Jefferson Avenue line. The cars ran for a stretch of three miles. There was great rejoicing when, on August 3, the citizens were invited to ride free all day long at the breathtaking speed of six miles per hour. On August 27, the line on Woodward Avenue was opened. It did not cover much distance but it was a great convenience.

* * *

"FIRE ENGINES run by steam were introduced. Hand-fire-engine companies were disbanded and groups of men to man the new engines were formed. In 1865 a public library was started in the old Capitol Building. Cobblestone pavements were replaced by cedar blocks. A national bank system was created in 1863, and at the close of the year the First National Bank and also the Second were opened for business.

"When, on April 3, 1865, news reached Detroit that the southern troops had left Richmond, their capital, the people were delighted. They set off fireworks and sang patriotic songs, but the news of the surrender of Lee at Appomattox on April 9 caused almost a frenzy of joy. Bonfires blazed everywhere. Many placed lights in every window of their homes.

"For five joyous days, nothing was thought or spoken of but the glad news. Then came the awful tidings of the assassination of President Lincoln by John Wilkes Booth, and the entire nation was plunged into grief in a single night.

"Funeral services were held all over the country to commemorate the passing of this man, who was so truly the friend of humanity. In Detroit, houses and stores were hung with black and, on April 25, all stores and schools were closed, and almost the entire population assembled on the Campus Martius to view a procession over two miles long that marched to solemn dirges. The Honorable Jacob Howard gave the funeral oration. May 30 was observed as a national day of prayer and fasting.

* * *

"IN 1859, Walter Harper and his housekeeper, Mrs. Nancy Martin, had offered their large tract on Woodward Avenue and their land holdings in other places for a hospital. In return, the city was to provide them with a home and an annual income for life. Because a hospital was needed immediately, many small white buildings were put up on this land. Thus, in 1866, Harper Hospital was opened. While waiting for these buildings to be finished, the sick and wounded were cared for in a little colony of tents.

"On June 17, 1866, General Lewis Cass passed away at the age of eighty-four. The city was draped in mourning, flags were at half-mast, and hundreds flocked to his home on West Fort Street to gaze upon his face for the last time. Dr. George Duffield and Bishop Samuel A. McCoskry conducted the services at the Presbyterian Church, and a long line of citizens, headed by four companies of the 4th United States Infantry escorted the remains to Elmwood Cemetery where the gateway of the family lot was draped in black. His memory as our foremost citizen is revered to this day.

* * *

"THE CITY FELT well enough off to warrant the building of a new City Hall and the work was started in 1863. The last year of the sixties saw the opening of the Detroit Opera House on the Campus Martius. On the ground floor was located the largest dry-goods store of the city—Newcomb and Endicott. The Detroit Medical College was opened. It became very noted and is now a part of Wayne University. At this time, colored children were first admitted to the public schools."

THE FOLLOWING STORY APPEARED IN THE DETROIT FREE PRESS, JUNE 6, 1866, WITH THE HEADING IN THE FOLLOWING STYLE:

MEETING OF THE MEDICAL FRATERNITY OF THE STATE

FORMATION OF A STATE MEDICAL SOCIETY

The Organization

About one hundred members of the medical profession of the state assembled in convention yesterday o'clock p.m., at the Supreme Court room of this city, for the purpose of forming a State Medic Society.

The convention was organized by calling Dr. Moses Gunn to the chair, and appointing Dr. Samuel Axford, of Flint, Secretary. Dr. Morse Steward, on behalf of the profession in this city, then addressed the convention as follows:

* * *

"PHYSICIANS OF MICHIGAN—Gentlemen: I am honored by being called to represent the fraternity of Detroit in welcoming you to our city. The business which has brought you among us, concerns every member of the profession throughout the state, and I scarcely need to assure you that we here are in full sympathy in respect to this matter with our brethren from the interior. The truth is, by neglecting to keep up our organization during the last four years, we have failed to promote as far as possible individual growth and development, the advancement of medical science, and through these the great and ultimate object of our profession, the welfare of the society.

"While interests as important as those which concern the lives and health of our fellow men are intrusted to us, we should be derelict to omit the means concerning them. All experience teaches that concern of action and thought is essential in every enterprise in which committees are engaged. Especially in this case with the practice of medicine; for in it there is need as much for analysis, classification and arrangement, as for close and careful observation of numerous and varied phenomena, in educing facts and evolving principles which are to be the guide of coming generations. In medicine peculiarly, experience is the great educator, and every physician, whatsoever his talent or position in society, may and ought to give his quota to the general stock; but it all needs to be assorted and combined.

"For this purpose organization and union are indispensable. We have come together now, to atone for the past, and by this re-union to re-organize and re-vivify our State Medical Society. How, with almost an oppressive sense of personal responsibility, in view of the relation which our profession sustains to the well-being of man, and with hearts expanded by an enlarged charity so as to exclude individual and selfish aims, should we enter upon the duties which are before us. I doubt not, gentlemen, that under the promptings of such feelings you have assembled here; and that your deliberations will be marked by harmony, and so conducted as shall lend to the increase and diffusion of medical knowledge amongst us. In behalf of Detroit and her citizens, I bid you, as representatives of the various sections of our still young, but already great and prosperous Michigan, a cordial welcome to this her commercial capital."

* * *

ON MOTION OF DOCTOR PLATT, of Grand Rapids, a committee of five was appointed to draft a constitution and by-laws. Doctors Pratt, of Grand Rapids, Armor of Detroit, Wood of Grand Rapids, Ranney of Lansing, and Adrews of Niles, were appointed such committee.

It was moved that the convention take a recess in order to give the committee time to draft a constitution and by-laws.

On the reassembling of the convention the report of the committee was received and accepted.

Doctor Brodie moved that the constitution be taken up section by section, and accepted or rejected. Motion carried.

* * *

THERE WAS CONSIDERABLE debate upon each section of the constitution, but it was finally adopted without alteration.

CONSTITUTION

The association shall be called the "Michigan State Medical Society," and shall be composed of resident and honorary members.

The society shall constantly have in view:

1. The association of the profession, for the purpose of mutual recognition and fellowship.

2. The maintenance of union, harmony and good government amongst the members, thereby promoting the character, interest, honor and usefulness of the profession.

3. The cultivation and advancement of medical science, of literature, and the elevation of the standard of the professional education.

The resident members shall be regular practitioners of medicine and surgery in the state of Michigan, who shall be elected by vote of a majority at any regular meeting, their eligibility having been previously reported upon by the Committee of Admission, provided no member shall be eligible to membership who is not a member of a local society when such society exists.

* * *

HONORARY MEMBERS shall only be admitted by a vote of two-thirds of the members present at a regular meeting, having been first recommended by the Committee of Admission. The whole number of honorary members shall not exceed 100.

A vote of two-thirds of the members present shall be requisite for the expulsion of a member, which vote shall be had in consequence of a report from the Committee on Ethics, and at the next regular meeting subsequent to such report.

The officers of this society shall be a president, four vice presidents, a corresponding and recording secretary, and a treasurer; all of whom shall be elected annually, except the recording secretary, who shall hold his office two successive years, by ballot and a majority vote, at the regular meeting. They shall severally perform the duties assigned in the by-laws, as shall also the standing committee.

The following standing committees shall be annually appointed by the president, and shall each consist of five members: First, an Executive Commitee; Second, a Committee on Finance; Third, on Publication; Fourth, on Medical Ethics.

A standing Committee on Admission of like number shall be elected by ballot, and a majority vote, at the same meeting, annually.

No part of this constitution shall be repealed, annulled, altered or amended, except at a regular meeting subsequent to one at which a proposition to that effect may have been made in writing, and then only by a vote of four-fifths of all the members present.

* * *

THE BY-LAWS were voted on and adopted by sections also, and finally adopted as a whole. The principal ones are as follows:

The regular meetings of the Society shall be held annually, at such time and place as the Society may from time to time determine.

At all meetings the presence of 15 resident members shall be necessary to constitute a quorum.

The president shall be elected annually, at the regular meetings.

The expenses of the Society shall not exceed $100 per annum. To defray the incidental expenses of the Society a tax will be assessed pro rata.

Every member, on admission, shall pay the sum of $2.00 as an entrance fee, and sign the constitution and by-laws; nor shall he be entitled to the right of membership until the same is done.

That the Society adopt the code of medical ethics of the American Medical Association.

CYRUS M. STOCKWELL, M.D.
Port Huron
First MSMS President

The organizational meeting of MSMS was held in the State Supreme Court in the Oddfellows Hall on Woodward Avenue between Congress and Larnard. The site will be marked September 19 by the Michigan Historical Commission.

ELECTION OF OFFICERS

The following gentlemen were elected officers of the society:

President—Dr. C. M. Stockwell, Port Huron

First Vice President—Dr. A. Platt, Grand Rapids

Second Vice President—Dr. J. H. Jerome, Saginaw City

Third Vice President—Dr. J. H. Beach, Coldwater

Fourth Vice President—Dr. E. J. Bonine, Niles

Treasurer—Dr. Henry F. Lyster, Detroit

Recording Secretary—Dr. G. R. Ranney, Lansing

Corresponding Secretary—Dr. G. P. Andrews, Detroit.

The following gentlemen were appointed a committee on admission: Doctors Platt, Grand Rapids; Stebbens, Armor, Stewart, and Brumme, Detroit.

A communication from the mayor was then read by the secretary, inviting the convention to visit the House of Correction at 9 o'clock.

EVENING SESSION

A resolution was passed to accept the invitation of the mayor to visit the House of Correction.

It was resolved that when the convention adjourn it adjourn to meet on the first Wednesday in June, at such place as the society shall appoint.

It was then moved that the "State Medical Society" hold its next meeting in the city of Detroit. Carried.

* * *

DOCTOR JEROME, of Saginaw, moved that committees of three members each be appointed to report at the next annual meeting upon the following topics, to wit: 1. medical hygiene; 2. vital statistics; 3. surgery; 4. practice of medicine; 5. obstetrics; 6. zomotic diseases; 7. epidemics; 8. to examine all voluntary contributions of members, and select such as they shall deem proper for presentation to the society.

On the committees above named the following gentlemen were appointed: On Medical Hygiene, Drs. A. B. Palmer, Ann Arbor; D. O. Farrand, Detroit; Z. Paddock, Pontiac. Vital Statistics, Drs. Stewart and Noyes, Detroit; Dr. Richardson, Niles. Surgery, Drs. Gunn and Lyster, Detroit; Knight, of Utica. Practice of Medicine, Drs. Axford, Flint; Andrews, Detroit; Tapher, Bay City. Obstetrics, Drs. E. W. Jenks, Detroit; Pleaner, Saginaw City; Chipman, Grand Rapids; J. A. Brown, Detroit; and E. R. Christian, Wyandotte. Epidemics, Drs. DeCamp, Grand Rapids; Connell, Ionia; Mitchell, Saginaw City. To Examine Voluntary Contributions, Drs. Theodore A. McGraw, E. W. Jenks and John Brady, of Detroit.

The society voted to sustain by their subscription and patronage the "Detroit Review of Medicine and Pharmacy."

* * *

THE FOLLOWING members were elected delegates to the American National Convention: Drs. J. P. White, Saginaw; D. A. Post, Ypsilanti; C. T. Southworth, Monroe; DeCamp, Grand Rapids; J. R. Thomas, Bay City; Wm. Brownell, Utica; T. Foster, Kalamazoo. The following committees were appointed: Executive Committee, consisting of Doctors Armor, Pitcher and Brown, of Detroit; Publication, Doctors Andrews and Lyster, Detroit, and Ranney, of Lansing; Medical Ethics, Lathrop and Farrand, Detroit, and A. Piatt, Grand Rapids.

The Society then adjourned.

* * *

Note: Physicians serving Michigan were first organized as the "Michigan Medical Society" under territorial laws on August 10, 1819. This organization lapsed in 1851 and the doctors reorganized as the Peninsula Medical Society, March 30, 1853. The approach of the Civil War was the major reason for the decline of that organization in 1860. Then after a six-year lapse, about 100 physicians met in Detroit, June 5, 1866, to organize the present Michigan State Medical Society.

OUR STATE SOCIETY

MSMS-Supported Law Requires Each County Have Health Units

A goal of MSMS and the Michigan Department of Health was realized when the Michigan Legislature passed a law requiring every county provide public health protection. The new law took immediate effect when signed by Governor Romney, on July 21, 1965.

The 12 counties affected by the new law are Gogebic, Marquette, Luce, Mackinac, Huron, Tuscola, Lapeer, Jackson, Montcalm, Ionia, Clinton, and Gratiot.

The other 71 counties are served by local health departments, either singly, in pairs, or combinations of three, four or five counties.

Along with the requirements that counties provide public health services either by establishing a health department or joining with another county or group of counties, the new law increases the amount of state financial aid from $5,000 per county to a minimum of $7,000. Although most counties will receive only a $2,000 boost, some of the more populous counties will receive substantial increases.

As a result of this legislation, Michigan will become one of the few states with 100 per cent coverage by local health departments.

We read with keen interest your digest of the Conference on Medical Writing.

If you have extra copies, I would greatly appreciate as many as you can spare.

Sincerely,
Frank Chappell
Director of Science News
American Medical Association

OFFER INFORMATION ABOUT TETRACYCLINE

The following information is presented by the MSMS Maternal Health Committee for Michigan physicians about tetracycline:

The high incidence of tetracycline stain in both permanent and deciduous teeth is causing great concern among many dentists and many pediatricians. The time that the tetracycline is given will determine which teeth are stained. If the tetracycline is given during the last four months of pregnancy or the first seven months after birth the staining will be in the deciduous teeth. If the tetracycline is given after the eighth month of life the permanent teeth are in their calcification process and staining will occur in these teeth. There is no question with the present evidence that staining occurs just as severely in the permanent teeth as in the deciduous ones. When the tooth first erupts the yellow color is quite bright and as the tooth is exposed to light a photo-chemical reaction takes place and a gray color will be the end result in the permanent tooth, after it has erupted for some time.

A period of tetracycline treatment during the formative tooth period for as short as five days can cause permanent change in the color of the tooth. The frequency of tooth stain is much higher among private patients than in clinic patients because this drug is used mostly in areas where the patient can afford an expensive antibiotic. In two surveys, one in Oneida, New York, and another in Kalamazoo, Michigan, the incidence in private practice was 25 per cent.

Tetracycline can stain teeth any time during the period of the calcification of the tooth. This means that children up to age eight may get staining of the teeth because calcification of all teeth except the third molar is going on until the eighth year.

Since there is a broad group of antibiotics available that do not stain the teeth there is only a rare instance where tetracycline has to be used and certainly should be reserved in growing children so that they will not have permanent and disfiguring tooth change.

Overhead Insurance Available from MSMS

The new Professional Overhead Plan for MSMS is now in force. This policy is designed to cover the following expenses that continue during a period of total disability for as long as two years: rent, electricity, heat, water, laundry, employees' salaries, depreciation, membership fees and dues, contributions, and other normal expenses.

Premiums are a tax deductible business expense.

Information about this new MSMS insurance program may be obtained from the MSMS Headquarters, P.O. Box 152, East Lansing.

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References: 1. Goldsmith, J. W.: Minn. Med. (Feb.) 1957. 2. Groskloss, H. H., Clancy, C. L., Healey, E. F., McCann, W. J., Maloney, F. D., Loritz, A. F.: Clinical Medicine (Sept.) 1955. 3. Codling, J. W., Lowden, R. J.: Northwest Med. (March) 1958. 4. Bethea, R. C.: International Record of Med. (May) 1960. 5. Lenz, W., Second International Conference on Congenital Malformations, N. Y., N. Y., (July) 1963.

Side effects: the incidence of drowsiness and other atropine-like effects is low. However, caution patients engaged in activities where alertness is mandatory.

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Abstract of MSMS Council Action

Meeting of July 22-23, 1965

COUNCILOR DISTRICT CONFERENCES

Councilors were urged to schedule, at an early date, Councilor Conferences with Delegates and Alternate Delegates, Component Society Presidents, Presidents-Elect, and Secretaries, and Executive Secretaries, plus MSMS Officers. Notices and agenda for the meeting will be sent out by the MSMS headquarters office.

PROGRESS REPORT ON MSMS JUDICIAL COMMISSION

The Council received a report of progress from the chairman, Orlen J. Johnson, M.D., of the MSMS Judicial Commission and reviewed copies of proposed amendments to the Constitution and Bylaws to implement the recommendations of the Commission. The Council concurred in the plans of the Commission that copies of the proposed Constitution and Bylaws amendments be sent to each MSMS Delegate and Alternate Delegate, President and Secretary of each component society, and Councilors as soon as possible. This is one of the matters to be discussed at the Conferences.

APPOINTMENT OF CHAIRMAN OF CENTENNIAL NEWS COMMITTEES

Council appointed Milton R. Weed, M.D., Detroit, chairman of the Centennial News Committee; and named Speaker—James J. Lightbody, M.D., chairman of the House of Delegates Centennial News Committee.

ANNUAL REPORT OF MICHIGAN MEDICAL SERVICE

President Sidney Adler discussed various points including merit rating, House of Delegates resolutions, Blue Shield finances, Planning and Marketing, and Public Relations.

PRELIMINARY REPORT ON RESULTS OF MALPRACTICE INSURANCE SURVEY

The Council received a preliminary report on the results of the Malpractice Insurance Survey sent out by MSMS in May. Council instructed that the total survey report, plus an interpretation, be included in the annual report of The Council for report to the House of Delegates.

HEALTHMOBILE PROJECT

The Council authorized preliminary expenses for the development of the interior of the Healthmobile which will be one of the MSMS features of its Centennial Year. The very large trailer is being donated by a trailer manufacturing company and the trailer with many exhibits installed inside will tour component societies during the MSMS Centennial Year.

MSMS AFFILIATE MEMBERSHIP

Upon recommendation of the County Societies Committee, The Council adopted the following concept and policy:

"Affiliate memberships may be initiated at the Component Medical Society level, from which recommendations for Affiliate membership are made to The Council of MSMS, or they may be initiated by The Council in the first instance."

This recommendation was referred to the Standing Committee on Constitution and Bylaws for presentation to the House of Delegates.

SPECIAL REPORT OF RELATIVE VALUE STUDY COMMITTEE

The Council approved the RVS Committee's recommendation in that copies of the new RVS be sent to Michigan Medical Service for the purpose of monetary interpretation only. Copies of the 1965 RVS Study will be distributed in advance of the 1965 meeting of the House of Delegates to Delegates. Each copy will be marked, "This copy submitted for information and review only. It has not been acted upon by the House of Delegates. It is not official." Council also authorized sending the RVS Study, 1965, to all the representatives of the major specialty groups which had conferred with the RVS Committee over the past year. In addition, The Council approved the 1965 Relative Value Study with special commendation to the Committee which prepared it and referred the Study to The House of Delegates to develop necessary policies for its implementation. The Council also agreed to consider the designation for 1965 of a $5.00 monetary value per unit as representative of the usual customary fees for 1965 Relative Value Study.

POSTGRADUATE MEDICAL EDUCATION

Council approved the Postgraduate Medical Education Committee's recommendation that the 1965 MSMS Fall Postgraduate activities follow the successful pattern of the 1965 Spring series with lectures in about sixteen communities and a combined afternoon clinical program and evening lecture at three or four interested communities.

REPORTABLE DISEASES

Upon recommendation of the MSMS Cancer Control Committee, The Council approved that leukemia and lymphomas be made reportable diseases in order to facilitate the epidemiological investigations which are clearly justified.

REHABILITATION DIRECTORY

Council authorized additional distribution of the Rehabilitation Committee's "Rehabilitation Directory" to all hospital libraries in Michigan; it authorized publication of additional copies to be available to MSMS members upon request.

FULLTIME CHAIRS OF PREVENTIVE MEDICINE AND PUBLIC HEALTH

Council approved a recommendation of the Public Health Committee that The Council again urge establishment by Michigan's medical schools of fulltime chairs of preventive medicine and public health.

MEDICAL SOCIO-ECONOMIC POSITION PAPERS

Council authorized the Medical Socio-Economic Committee to proceed in involving experts to prepare "position papers" dealing with the environment in which medicine will be practiced in 1980. The Council also authorized that a copy of the Blue Cross Emergency Room study be sent to each component medical society Medical Economic Committee with a suggestion that a similar modified study be conducted within the confines of their respective medical society and that the results be made available to each hospital staff concerned.

DISCUSSIONS WITH SPECIAL GUESTS

As it has in previous years, The Council met with representatives of the following organizations to discuss matters of mutual interest: 1. Michigan Health Council, 2. Michigan Hospital Association, 3. Michigan Crippled Children Commission, 4. Michigan Medical Service, and other special guests.

MEDISCENE

Sept. 16-19—American Medical Writers Association, Statler Hilton, Detroit.

Sept. 19-24—MSMS Centennial Session, Cobo Hall and Sheraton-Cadillac Hotel, Detroit.

Sept. 21-24—Woman's Auxiliary to Michigan State Medical Society, Ponchartrain Hotel, Detroit.

Sept. 21-24—5th Annual Michigan "Doctors and Wives" Art Exhibit, Cobo Hall, Detroit.

Sept. 22-23—Michigan Medical Assistants Society Annual Meeting, Statler Hilton, Detroit.

Oct. 6-7—American Cancer Society, Michigan Division Annual Meeting, Civic Center, Lansing.

Oct. 7-8—Michigan Gerontology Society, Fall Meeting, Kalamazoo.

Oct. 15-16—U-M Medical Center Alumni Conference, Ann Arbor.

Oct. 20-21—Michigan Tuberculosis & Respiratory Disease Association, Kellogg Center, East Lansing.

Oct. 21—Michigan Thoracic Society, Kellogg Center, East Lansing.

Oct. 28-30—Michigan Society for Crippled Children and Adults, Park Place Motor Hotel, Traverse City.

Nov. 3—Diabetes Day, Genesee County, Flint.

Nov. 4—Southwestern Michigan Clinic Day, Battle Creek Country Club.

Nov. 7-13—Community Health Week, throughout Michigan.

Nov. 10-11—Symposium on Reproductive Physiology, Harper Hospital Medical Center, Detroit.

Dec. 2—Saginaw Academy of General Practice—Vascular Clinic Day, Bancroft Hotel, Saginaw.

OFFER MSMS DIRECTORY OF REHABILITATION FACILITIES

Interested MSMS members may obtain from the MSMS headquarters a new Directory of Michigan Medical Facilities for the Physically Impaired. The directory was compiled by the MSMS Committee on Rehabilitation. The project was undertaken "to provide individual physicians and others with information regarding rehabilitation facilities and services for the physically impaired."

The directory, authorized by The MSMS Council, has been distributed to each county society secretary and other interested physicians.

To obtain a copy, write to MSMS, Box 152, East Lansing.

Leads Macomb TB Association

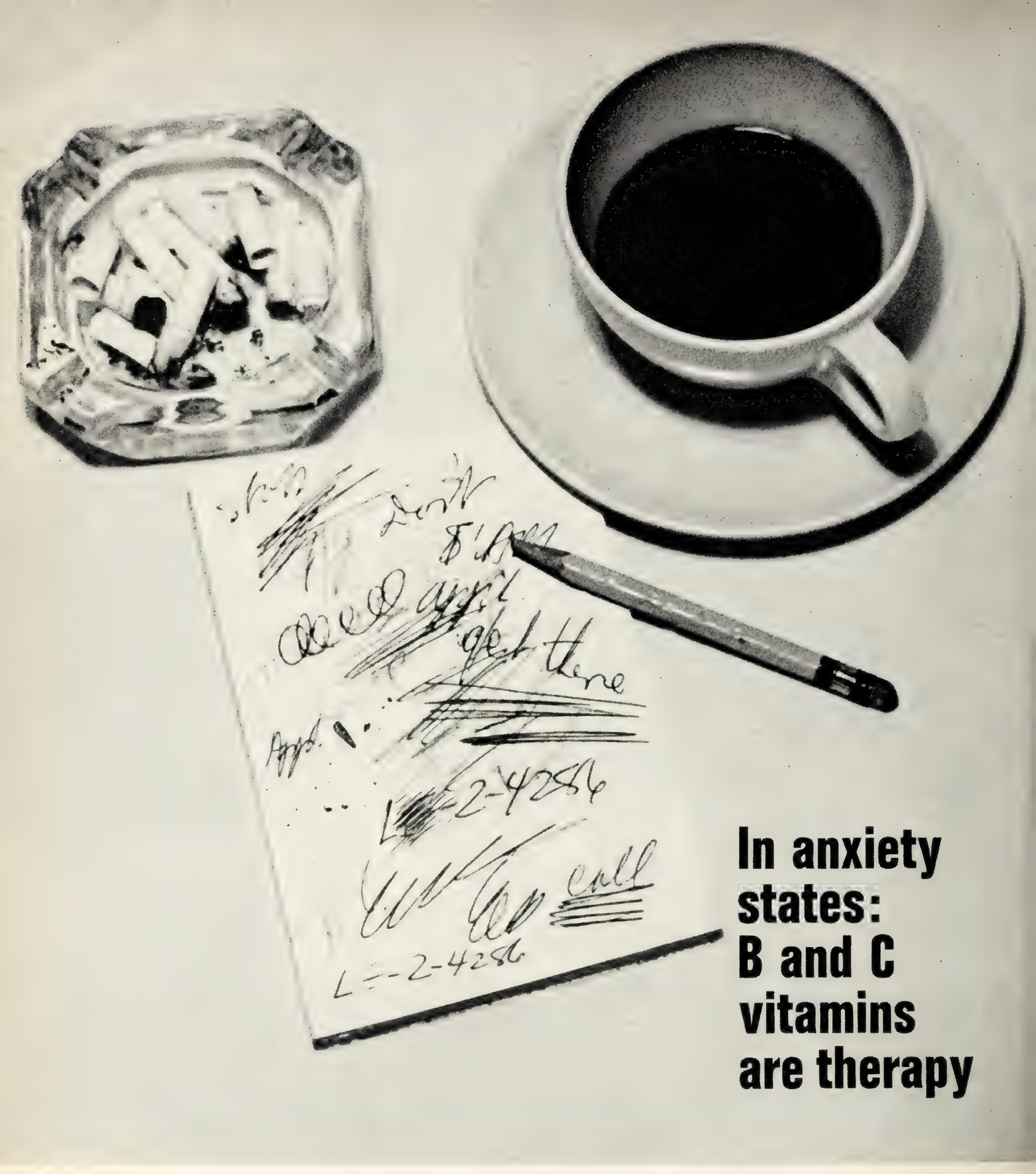
D. Bruce Wiley, M.D., of Utica, secretary of the Michigan State Medical Society, recently was elected president of the Macomb County Tuberculosis and Health Association.

On AMA Calendar

Here are the places and dates approved for the Annual and Clinical Conventions of the American Medical Association through June, 1968:

Clinical conventions: 1965—Philadelphia, Nov. 28-Dec. 1; 1966—Las Vegas, Nev., Nov. 27-30; 1967—Houston, Texas, Nov. 26-29.

Annual Conventions: 1966—Chicago, June 26-30; 1967—Atlantic City, N. J., June 18-22; 1968—San Francisco, June 16-20.



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Meetings of Medical and Ancillary Groups During Centennial Session

Tuesday, September 21

THE MICHIGAN DIABETES ASSOCIATION will meet for cocktails and dinner beginning at 5:30 p.m., Crystal Ballroom, Sheraton-Cadillac Hotel, Detroit. All registrants at the MSMS Centennial Session are invited to the dinner and to hear the speaker, Thaddeus S. Danowski, M.D., of Pittsburgh, Pennslvania.

Reservations can be sent to Keats K. Vining, Jr., M.D., 515 Lakeside Drive S.E., Grand Rapids.

THE MICHIGAN SOCIETY OF NEUROLOGY AND PSYCHIATRY and MICHIGAN DISTRICT BRANCH of the AMERICAN PSYCHIATRIC ASSOCIATION will meet for cocktails at 6:00 p.m., followed by dinner at 7:00 p.m. and a scientific program at 8:00 p.m. All events will be in the Woodward Room of the Sheraton-Cadillac Hotel in Detroit.

For reservations write Raymond Buck, M.D., Receiving Hospital, Detroit.

THE MICHIGAN SOCIETY OF OBSTETRICIANS AND GYNECOLOGISTS will meet at 10:00 a.m. in Room 3038 of Cobo Hall, Detroit. The speaker is Sprague H. Gardiner, M.D., Indianapolis. His subject is "The Impact of Obstetric Care on Population Control."

THE MICHIGAN ORTHOPAEDIC SOCIETY will hold its Annual Dinner Meeting at Dearborn Inn at 6:30 p.m. in Dearborn. For information write Curtis M. Hanson, M.D., 403 Bronson Medical Center, Kalamazoo.

THE MICHIGAN COMMITTEE ON TRAUMA, AMERICAN COLLEGE OF SURGEONS will hold a 12:00 noon luncheon—meeting in Room 3042 of Cobo Hall.

For information write: Franklin V. Wade, M.D., Chairman, 1121 Mott Foundation Bldg., Flint.

Wednesday, September 22

THE MICHIGAN ALLERGY SOCIETY will meet for luncheon at 12:30 p.m. in Room 3184 of Cobo Hall in Detroit. At 1:30 p.m., Edward A. Carr, Jr., M.D., Professor of Pharmacology and of Internal Medicine, University of Michigan Medical Center, Ann Arbor, will talk on "The Pharmacology of Drugs Used in Allergy."

For reservation write: Peter P. Barlow, M.D., 31815 Southfield Road, Birmingham.

THE MICHIGAN SOCIETY OF ANESTHESIOLOGISTS, INC., will hold a business meeting from 3:00 to 5:00 p.m. in Room 3035 of Cobo Hall. This meeting will immediately follow the scientific program sponsored by the MSMS Section on Anesthesiology from 12:30 to 3:00 p.m. (including luncheon), Room 3035 at Cobo Hall. A panel presentation on "Bread and Butter Pediatric Anesthesia" will be given by Moderator Donald W. Hesselschwerdt, M.D., of Grand Rapids, Speaker Robert M. Smith, M.D., of Boston, and Panelists Shirley Austin, M.D., Detroit and Frederico Arcari, M.D., Detroit.

For information regarding the business meeting of the Michigan Society of Anesthesiologists, Inc., write: John W. Ditzler, M.D., 581 Rivard, Detroit.

THE MICHIGAN ASSOCIATION OF NEUROLOGICAL SURGEONS will hold its second Annual Meeting beginning at 4:00 p.m. in Room 3177 of Cobo Hall. A business meeting will be followed by cocktails and a presentation of the film entitled "Maganga" (an actual film of neurological surgery performed by primitive people in Africa.) Subsequently dinner will be held, to be followed by the guest speaker, John S. Meyers, M.D., Versailles, Ohio, who will speak on the "Stroke Aspect of the President's commission for Heart Disease, Cancer and Stroke."

For information write: H. Harvey Gass, M.D., 529 Fisher Building, Detroit.

THE DETROIT OTOLARYNGOLOGICAL SOCIETY will meet jointly with the MSMS Section on Otolaryngology. This will be a luncheon meeting from 12:30 to 3:00 p.m. in Room 3045 of Cobo Hall, Detroit. Speaker of the day is Theodore E. Walsh, M.D., St. Louis, Missouri, who will discuss "The Management of Bell's Palsy."

For information write: L. Reed Cranmer, M.D., 3939 Monroe, Toledo 6, Ohio. Request for luncheon reservation may be sent direct to the Michigan State Medical Society, Box 152, East Lansing.

THE MICHIGAN ACADEMY OF PLASTIC SURGERY will meet in Room 3036 of Cobo Hall, Detroit, for luncheon at 12:00 noon. A scientific program will be presented from 2:00 to 5:00 p.m.

For information write: Andrew E. Stefani, M.D., 1117 David Whitney Bldg., Detroit.

THE BLACKWELL NO. 20 BRANCH OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION, celebrating the Golden Anniversary of the Founding of the Organization, will meet at special tables during the MSMS Centennial Banquet, which begins with cocktails at 7:00 p.m. in Ballroom A of Cobo Hall, Detroit.

For information write: Clara Raven, M.D., President, 400 E. Lafayette St., Detroit. For dinner reservation write the Michigan State Medical Society, Box 152, East Lansing, indicating that you are a member of the Blackwell No. 20 Branch, AMWA.

THE MICHIGAN PROCTOLOGIC SOCIETY will meet in Plaza Room C of The Pontchartrain Hotel in Detroit for cocktails at 6:30 p.m., dinner at 7:00 p.m. and a scientific meeting at 8:00 p.m. The speaker is Vainutis K. Vaitkevicius, M.D., Detroit. Dr. Vaitkevicius will discuss "The Management of Advanced Cancer of the Colon at the M.E. Darling Memorial Center, Grace Hospital, Detroit."

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Thursday, September 23

THE MICHIGAN CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS will meet for cocktails at 6:00 p.m. and dinner at 7:00 p.m. in the East and West Rooms of the Sheraton-Cadillac Hotel, Detroit. Following dinner, there will be a scientific program, "Air Contamination, its Effect on Pulmonary Diseases"—W. G. Fredericks, M.D., Detroit. This paper will be followed by a symposium on air contamination with member participation introduced by the following brief discussions:

1. "Preventive Measures in Air Pollution"—M. Sterling, Chief, Detroit Bureau of Air Pollution.
2. "Pulmonary Inflammation Due to Air Contamination (Case Report)"—R. H. Hamburg, M.D., Detroit.
3. "Allergic vs. Inflammatory Pulmonary Lesions Due to Air Contamination"—G. L. Waldbott, M.D., Detroit.

For reservation write: James D. Fryfogle, M.D., President, CD No. 8, Medical Concourse, Northland Center, Southfield.

THE MICHIGAN SOCIETY OF PATHOLOGISTS will hold a business meeting at 10:00 a.m. in Room 3036 of Cobo Hall, Detroit. The MSP will also meet in conjunction with the scientific luncheon meeting sponsored by the MSMS Section on Pathology beginning at 12:30 p.m. in Room 3038 of Cobo Hall. Edward A. Gall, M.D., Cincinnati, Ohio, will present "Whither Pathology?" and conduct a slide seminar on "Diseases of Lymph Node and the Reticulolendothelial System."

For information write: Robert C. Horn, Jr., M.D., 2799 W. Grand Blvd., Detroit, and for luncheon reservation write the Michigan State Medical Society, Box 152, East Lansing.

THE MICHIGAN BRANCH of the AMERICAN ACADEMY OF PEDIATRICS will meet for cocktails at 6:30 p.m. and dinner at 7:00 p.m. in the Woodward Room of the Sheraton-Cadillac Hotel. The speaker is Harry A. Towsley, M.D., Ann Arbor, President, American Academy of Pediatrics, who will discuss "Continuing Education in Pediatrics."

For information and reservation write Ruben Meyer, M.D., 5224 St. Antoine, Detroit.

THE MICHIGAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION will meet for luncheon at 11:30 a.m. in the Normandie Room of the Sheraton-Cadillac Hotel.

For reservation write: Frank Cullis, M.D., 261 Mack Blvd., Detroit.

THE DETROIT ROENTGEN RAY AND RADIUM SOCIETY will meet jointly with the MSMS Section on Radiology in Room 3039 of Cobo Hall, Detroit. "Roentgen Findings of Some Neurosurgical Abnormalities in Childhood" will be presented by Harold G. Jacobson, M.D., of Bronx, New York.

For reservation write the Michigan State Medical Society, Box 152, East Lansing.

THE EXECUTIVE COMMITTEE OF THE MICHIGAN STATE PHARMACEUTICAL ASSOCIATION will meet from 10:00 a.m. to 5:00 p.m. in Room 3080 of Cobo Hall, Detroit.

For information write: Robert C. Johnson, M.S., Executive Secretary, Michigan State Pharmaceutical Association, 1812 Michigan National Tower, Lansing 48933.

THE BOARD OF DIRECTORS, of the MICHIGAN BRANCH OF THE AMERICAN ACADEMY OF GENERAL PRACTICE will have a luncheon-meeting beginning at 12:00 noon in the Mason Room of the Sheraton-Cadillac Hotel, Detroit.

For information write: E. C. Long, M.D., 19751 James Couzens Highway, Detroit.

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Meetings of Alumni Groups During MSMS Centennial Session

BOSTON UNIVERSITY SCHOOL OF MEDICINE—6:00 p.m. reception and dinner on Tuesday, September 21, Mason Room, Sheraton-Cadillac Hotel in Detroit. Write Mr. Robert S. Fox, Executive Secretary, Alumni Association, 80 East Concord Street, Boston 02118.

THE UNIVERSITY OF BUFFALO—12:00 noon reception and luncheon and speaker, Room 3177 Cobo Hall, Detroit, on Tuesday, September 21. Write C. J. Young, Jr., Director, Alumni Affairs, The University of Buffalo Alumni Association, Buffalo, New York.

COLUMBIA UNIVERSITY COLLEGE OF PHYSICIANS AND SURGEONS—6:30 p.m. reception and dinner, Tuesday, September 21, Plaza Room C. The Pontchartrain Hotel, Detroit. Write J. Frederick Eagle, Jr., M.D., Assistant Dean, 630 West 168th Street, New York City.

UNIVERSITY OF ILLINOIS—Reception and dinner beginning at 6:00 p.m. on Tuesday, September 21, at the Pontchartrain Hotel in Detroit (Plaza Rooms A & B). Write Lee B. Stevenson, M.D., Henry Ford Hospital, Detroit.

JEFFERSON MEDICAL COLLEGE—Reception and dinner beginning at 6:00 p.m., Tuesday, September 21, at the Pontchartrain Hotel in Detroit (Ontario Rooms B & C). Write Joseph Eschbach, M.D., 935 South Military, Dearborn, Michigan.

THE UNIVERSITY OF WESTERN ONTARIO—Reception from 5:00 to 6:30 p.m., Room 3176 Cobo Hall, Tuesday, September 21. Write Dr. Dorothy Turville, Associate Alumni Director, London, Canada.

UNIVERSITY OF PENNSYLVANIA—Reception and dinner beginning at 5:00 p.m., Room 3043 Cobo Hall, in Detroit, Tuesday, September 21. Write Douglas C. Geary, Medical Alumni Office, Philadelphia, Pennsylvania 19104.

WASHINGTON UNIVERSITY—Reception from 5:00 to 6:30 p.m., Room 3178 Cobo Hall, Tuesday, September 21. Write Miss Audrey Wingfield, Executive Secretary, Medical Center Alumni Office, 501 South Euclid Ave., St. Louis, Missouri.

YALE UNIVERSITY—Reception from 5:30 to 7:00 p.m., Ontario Room A, Pontchartrain Hotel on Tuesday, September 21. Write Arthur Ebbert, Jr., M.D., Associate Dean, 333 Cedar St., New Haven, Connecticut.

The Michigan Alumni of the George Washington University will have a reception from 7:00 to 9:00 p.m., on Tuesday, September 21,

The State Chairman is R. J. Winfield, M.D., 3014 Main, Marlette.

The Michigan members of the following medical schools will sit together at the Century Luncheon to be held on Tuesday, September 21 in Ballroom A of Cobo Hall:

New York University School of Medicine
Marquette University
University of Louisville
Georgetown University
Cornell University.

THE MICHIGAN ASSOCIATION OF ALPHA KAPPA KAPPA—President Donald J. Barnes, M.D., of Pleasant Ridge, invites all AKK Brothers to cocktails at 6:00 p.m. and dinner at 7:00 p.m. at the Detroit Club, Tuesday, September 21. For reservation write: Lynn A. Ferguson, M.D., 72 Sheldon Ave. S.E., Grand Rapids.

THE WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE ALUMNI ASSOCIATION will have a hospitality suite at the Sheraton-Cadillac Hotel in Detroit with a special reception from 4:00 to 6:00 p.m. on Tuesday, September 21. Representatives of the university will be in attendance. All alumni, faculty, and friends are cordially invited. The headquarters suite will be maintained on Monday and Tuesday, September 20-21.

THE UNIVERSITY OF MICHIGAN MEDICAL CENTER ALUMNI SOCIETY will have a hospitality suite at the Sheraton-Cadillac Hotel in Detroit with a special reception from 5:00 to 7:00 p.m. on Tuesday, September 21. The headquarters suite at the Sheraton will be maintained from Sunday noon, September 19 through Wednesday, September 22.

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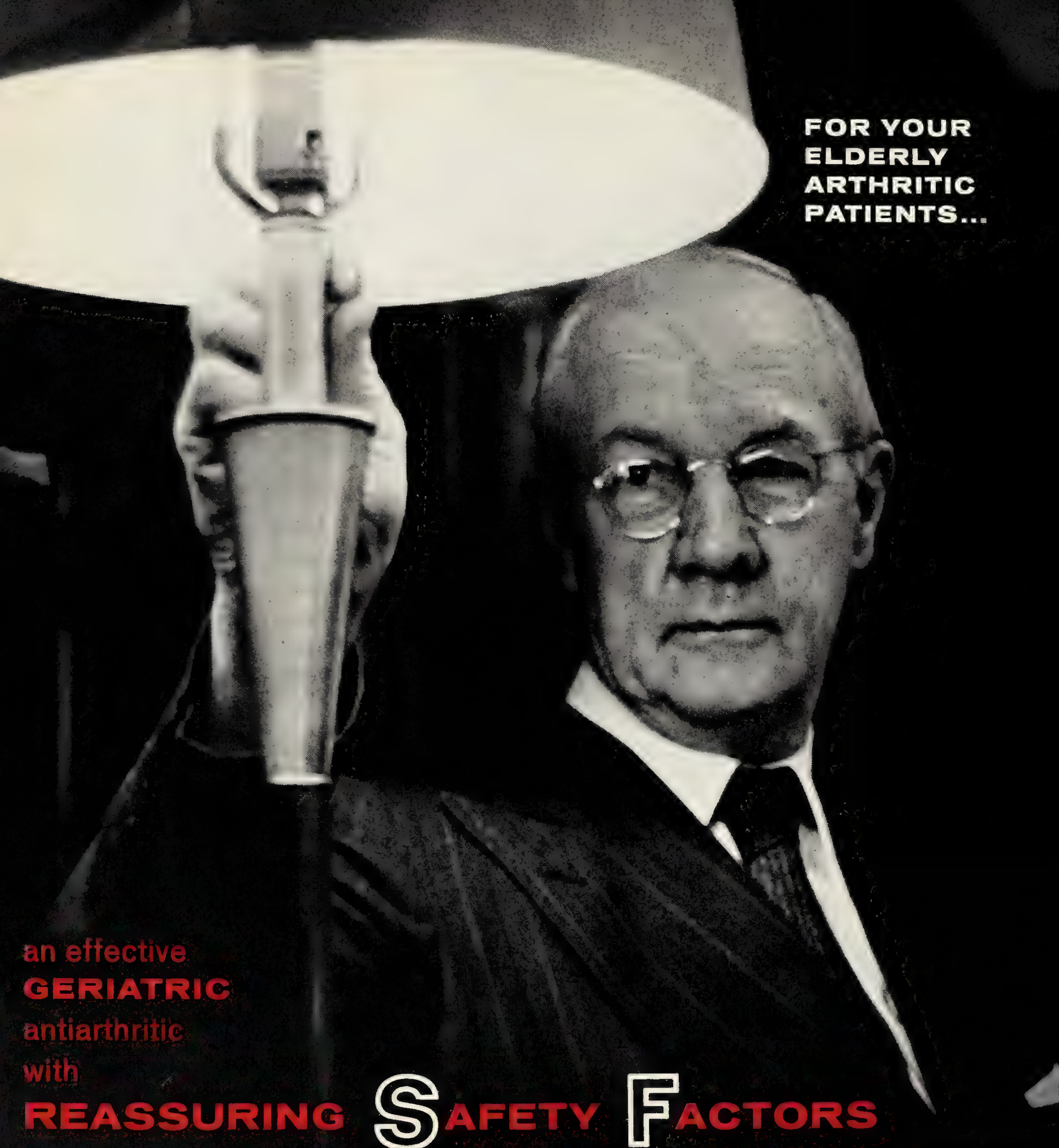

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Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

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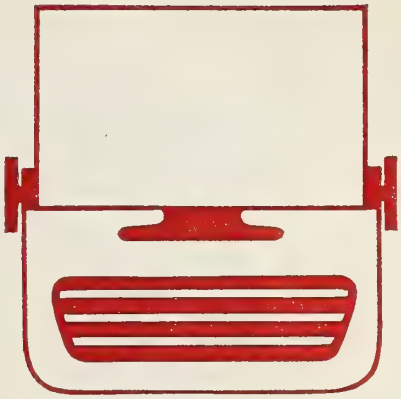

EDITORIAL VIEWS

OPPORTUNITY FOR NEW LEARNING

By Harry A. Towsley, M.D.
Chairman, Program Committee
Centennial Scientific Sessions

Members of the Michigan State Medical Society, on September 19-24, in Detroit, will participate in the 100th anniversary of the founding of their society and the commemoration of a heritage enjoyed by few, if any, other state medical societies.

The Michigan State Medical Society, from its early inception, was dedicated to providing scientific programs and continuing medical education opportunities for its membership.

Throughout the years, the Michigan State Society, in cooperation with Wayne State University, The University of Michigan and the Michigan State Department of Health, has provided programs of continuing education on a regional basis for the members of the component medical societies. The members of each faculty of our medical schools have contributed generously of their time and effort to this program.

* * *

THE CENTENNIAL SESSION of the State Medical Society provides a golden opportunity for cross-fertilization among the specialty groups and the family practitioners within the state.

This session is designed to broaden the horizons of that educational process. Each of the specialty sections has been provided with the opportunity to listen to outstanding teachers, clinicians and investigators from all over the United States. Lectures, clinical demonstrations and roundtable discussions of recent advances in diagnosis and therapy of a host of diseases confronting physicians in every day practice will be presented by leading authorities in their fields during the four day session.

In addition, color closed-circuit television will demonstrate outstanding techniques and procedures used in every day practice.

It is the sincere hope of the Program Committee of the Scientific Session that each member of the State Medical Society will make every effort within his means to attend this unusual meeting.

We shall be looking forward to seeing you at the Centennial Session.

URGE JUDICIAL COMMISSION

By O. J. Johnson, M.D.
MSMS Past President and Chairman,
MSMS Judicial Study Commission

Ten months ago, charged by the 1964 MSMS House of Delegates to prepare recommendations for providing a permanent Judicial Board and System for the Michigan State Medical Society, a 12-man study commission, appointed by the MSMS president, commenced one of the most momentous tasks in the 100-year history of the Society.

This month that commission will lay before the House its recommendations, including a new article for the MSMS Constitution, six amended bylaws sections and one new section, and an entire proposed new chapter to the MSMS bylaws, composed of nine sections and spelling out in detail the composition, powers and duties of a permanent Judicial Commission.

The recommendations as developed for the

House of Delegates represent a Herculean effort, spanning four study commission meetings in a period of eight months. At each step of the way, the commission measured its decisions by two basic yardsticks: the permanent Judicial Commission should be able to function completely independent from all other official bodies of the Michigan State Medical Society, and the Commission should be fully answerable to the membership of MSMS—the physicians of Michigan.

The study commission having completed its labors, the decision as to the final form of a Judicial Commission now rests with the House of Delegates, itself an institution created and selected by those it serves.

In the House of Delegates, 150 physicians, each elected by those he represents, will have ample opportunity to freely and openly discuss the study commission's recommendations. Amendments, if the majority considers them prudent, can be made. The end-product can and should be the most outstanding means yet devised whereby doctors of medicine can, themselves, assure the highest possible level of professional conduct.

Each delegate to the 1965 Centennial Session of the MSMS House of Delegates should review the study commission's recommendations in minute detail, discussing them with his constituency. The commission's report has been assigned to the House reference committee on constitution and bylaws, where it will be subject to intensive examination and where final language will be determined for submission to the full House of Delegates.

The members of the study commission, distinguished physicians all, have most conscientiously strived to develop a just and workable judicial system. Their recommendations reflect their combined abilities, wisdom and character. They are based upon reason and understanding, rather than preconception or bias.

A permanent Judicial Commission is proposed which will have vast jurisdiction and power, but which will still be a creature of the members of MSMS. While such a commission will not be vested with legal power in the sense that it will be authorized by law, it will be given the tools with which it can enact and enforce a body of rules which are inherently just.

J. R. Pedden, M.D., S. E. Andrews, M.D., H. A. Furlong, M.D., R. R. Cooper, M.D., W. H. Huron, M.D., K. H. Johnson, M.D., J. J. Lightbody, M.D., J. E. Livesay, M.D., N. F. Miller, M.D., J. R. Rodger, M.D., and A. E. Schiller, M.D., along with O. B. McGillicuddy, M.D., the committee advisor, merit the appreciation of all of their fellow physicians for the work which they have done. With the counsel of Lester P. Dodd, J.D., and other MSMS staff members, they have set forth the fabric of an exemplary Judicial system.

It can indeed be enthusiastically recommended to the 1965 House of Delegates.

NEW CHALLENGES IN 12 COUNTIES

By Otto K. Engelke, M.D.,
MSMS Past President, and
Legal Affairs Chairman,
Ann Arbor

Another plank for the "MSMS Presidents Program" is near achievement.

"Complete coverage of Michigan by local health departments" has been given a big assist by the legislature and the governor. Section I, Act No. 269, Public Acts of 1965 amending Act No. 306 of 1927 is now in effect as follows:

> *Section I, "The board of supervisors of each county in the state shall provide for a county health department, except where a district health department has been formed pursuant to Section 7, to be paid for out of the general fund of the county. If the county has a county health department the board of supervisors shall select a county board of health of five members, etc."*

* * *

COUNTY OFFICIALS and citizens in the 12 heretofore "unorganized" counties will soon have an opportunity to plan, establish and coordinate governmental public health activities with private services now available. The doctor whose health care is given in the home and in hospitals as well as the private health agency interested in research, education and service will now have an important ally.

(Continued on Page 714)

one place your hay-fever patient doesn't need **ORNADE®** (unless he has a cold)

Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

...but if your patient can't get away from hay fever, relieve sneezing, weeping and nasal congestion for 24 hours with one 'Ornade' Spansule® brand sustained release capsule q12h

Summary of contraindications, cautions and side effects: Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction. Use with caution in the presence of hypertension, hyperthyroidism, or coronary artery disease. Drowsiness; excessive dryness of nose, throat or mouth; nervousness or insomnia may occur on rare occasions but are usually mild and transitory.

Before prescribing, see SK&F product Prescribing Information.

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Doctors in the 12 counties most affected by the new state law have a wonderful opportunity to serve their counties by exercising early and continuous leadership in the establishment of new health departments. Memberships on the policy-making boards of health, while often time-consuming, can be very rewarding.

> *Doctors in the counties with operating health departments will not have the same chance to start fresh and grow with the total community health program. However, those who are willing to volunteer some time will find many chances to serve awaiting them.*

* * *

ORGANIZED MEDICINE'S best remaining hope for the development of mutually satisfying health care relationships in public and private service may be at the local level.

The services of an official local health department have not been available in Jackson, Lapeer, Huron, Tuscola, Montcalm, Ionia, Clinton, Gratiot, Mackinac, Luce, Marquette and Gogebic counties. They account for about 10 per cent of the state's population.

* * *

IN 1962 THE AMA House of Delegates adopted the following public health principles:

1. That the state and county medical societies be encouraged to evaluate periodically their public health department's activities in terms of local health needs, programs, and resources.

2. That state and county medical societies ascertain and acknowledge that public health departments should include *at least* the following basic services:

   a. Vital statistics
   b. Public health education
   c. Environmental sanitation
   d. Public health laboratories if private facilities are unavailable
   e. Prevention and control of communicable diseases
   f. Hygiene of maternity, infancy, and childhood, if private facilities are unavailable

in the overweight stable adult

...fasting serum levels of insulin are usually normal, postprandial levels excessive[1-3]

...insulin acts in adipose tissue via hexose monophosphate shunt, principal path of glucose conversion to storage fat[1,4]

...excessive endogenous insulin acts to stimulate lipogenesis and weight gain[1,3,4]

3. That the policy statement on public health services of the American Medical Association be as follows:

> Public health is the art and science of maintaining, protecting, and improving the health of the people through organized community efforts. It includes those arrangements whereby the community provides medical services for special groups of persons and is concerned with prevention or control of disease, with persons requiring hospitalization to protect the community and with the medically indigent.

4. That state and county medical societies should collaborate with departments of public health in the interest of community health, always keeping in mind the need for a proper balance between local public health programs and the private practice of medicine.

The 12 counties about to embark on local public health programs for the first time will want assistance in establishing their public health agency and implementing services in vital statistics, health education, sanitation, laboratories, control of communicable diseases, maternal and child health, etc.

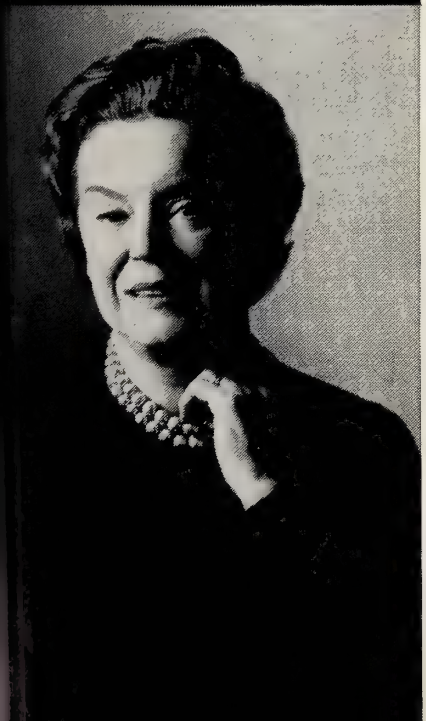
* * *

THESE ARE programs in the oldest tradition of public health. They have worked so well that communities are now turning their attention to other health problems. AMA recommendations three and four stated above are becoming more prophetic every day. These principles approve community organized efforts including those of official health agencies, in the provision and administration of "medical services for special groups . . ." These "groups" are getting larger. Welfare aspects of these programs are becoming less important. State and federal laws recently enacted like "Medicare" and the "Economic Opportunity Act" and others in process are moving local and state departments into ever-widening health and related medical care activities.

All physicians are challenged to develop new ways to work effectively with county health departments—and the Medical Society will be watching with interest the MSMS members in these 12 counties discussed above.

diabetic

..DBI lowers high blood
ugars without promoting
at synthesis, thus leads
o gradual weight loss[2-9]



to manage the overweight stable adult diabetic unresponsive to diet alone

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timed-disintegration capsules 50 mg.

DBI promotes glucose utilization via the physiologic Embden-Meyerhof pathway... reduces high blood sugars, lowers toward normal elevated blood insulin levels, thus leading to gradual weight reduction. Anorexia has been suggested as a possible basis for weight loss. However, controlled clinical studies suggest that it is due to the mechanism of drug action. Comparable dosages of DBI do not induce weight loss or lower blood sugar in nondiabetic subjects. For the ketoacidosis-prone diabetic, insulin is still the essential hypoglycemic agent.

Dosage: 1 to 3 capsules daily. **Side Effects:** Gastrointestinal, occurring more often at higher dosage levels, abate promptly upon dosage reduction or temporary withdrawal. **Precautions:** Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis which is accompanied by acidosis, and treated accordingly. Lactic acidosis has been reported in nondiabetics and diabetics treated with insulin, with diet, and with DBI. Question has arisen regarding possible contribution of DBI to lactic acidosis in patients with renal impairment and azotemia and also those with severe hypotension secondary to myocardial or bowel infarction. Periodic B. U. N. determinations should be made when DBI is administered in the presence of chronic renal disease. DBI should not be used when there is significant azotemia. Any cardiovascular lesion that could result in severe or sustained hypotension, which may itself lead to development of lactic acidosis, should be considered cause for immediate discontinuation of DBI at least until normal blood pressure has been restored and is maintained without vasopressors. Should lactic acidosis occur from any cause, vigorous attempts should be made to correct circulatory collapse, tissue hypoxia, and pH. **Contraindications:** Severe hepatic disease, renal disease with uremia, cardiovascular collapse. Not recommended without insulin in acute complications of diabetes (metabolic acidosis, coma, severe infections, gangrene, surgery). **Pregnancy Warning:** *During pregnancy, until safety is proved, use of DBI, like other oral hypoglycemic drugs, is to be avoided.*

Consult product brochure. **Also available:** DBI tablets 25 mg.

1. Gordon, E. S.: Metabolism 11:819, 1962. **2.** Grodsky, G. M. et al.: Metabolism 12:278, 1963. **3.** Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. **4.** Sadow, H. S.: Metabolism 12:333, 1963. **5.** Faludi, G.: J. Am. Med. Women's Assoc. 18:722, 1963. **6.** Faludi, G.: Geriatrics 18:452, 1963. **7.** Williams, R. H.: Textbook of Endocrinology, Ed. 3, Saunders, Phila., 1962, p. 610. **8.** Weller, C. and Linder, M.: Am. Therap. Soc., June 1963. **9.** Moss, J. M. et al.: Med. Times, July 1964.

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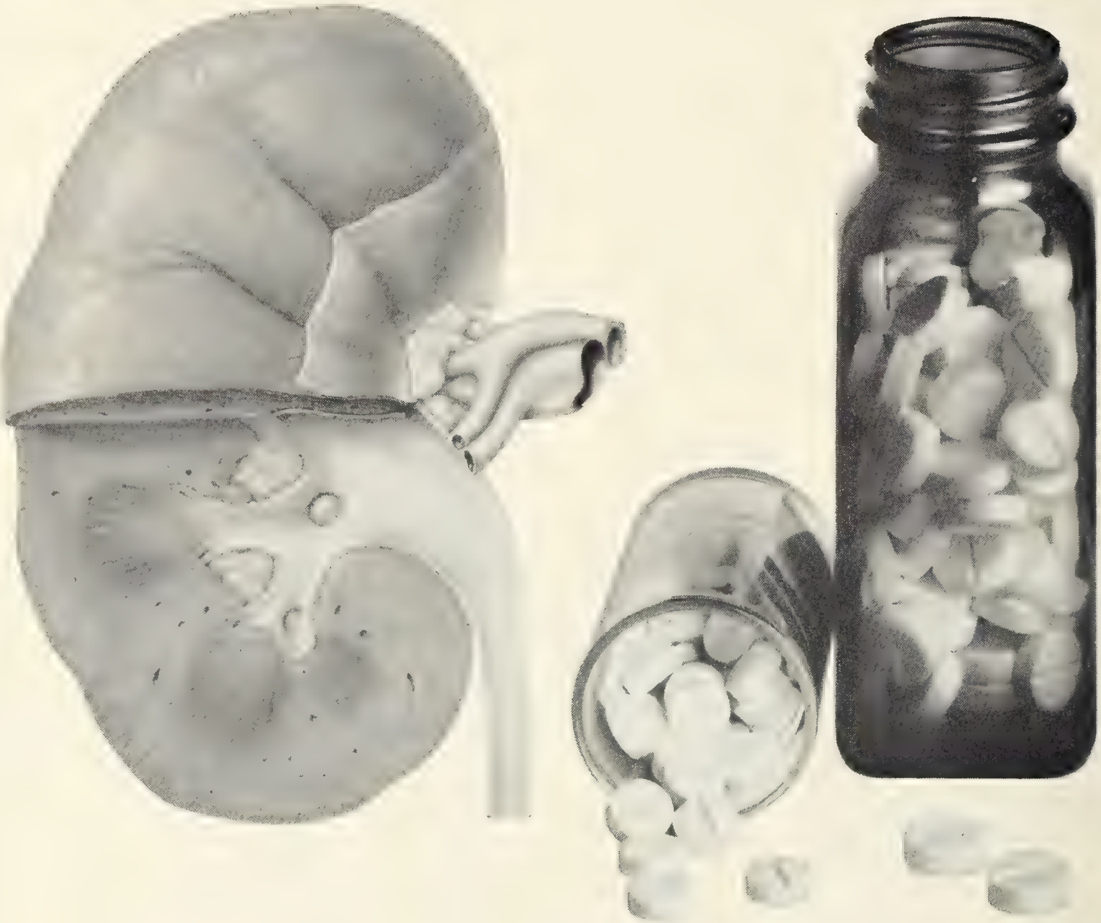

understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

- Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.
- From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

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where today's theory is tomorrow's therapy

ANCILLARY SECTION

Progress Report on Community Mental Health Activities

By the Michigan Department of Mental Health

Community mental health services are not new in Michigan but they are becoming more integrated and more comprehensive. County boards of supervisors, the state legislature and U. S. Congress are now combining efforts to provide more effective programs at the local level.

The comprehensive features of these community services are directed toward "crisis intervention" providing early diagnosis and effective treatment in the patient's home community and in cooperation with the family physician.

General practitioners are taking leadership roles in development of these local psychiatric services. To a great degree the success of the programs rests with them as they participate in the full complement of medical services, most especially in early diagnosis, appropriate referrals, and both inpatient and outpatient treatment programs.

The coordination and development of mental health services in Michigan have been given a significant boost through the Community Mental Health Services Act (P.A. 54) adopted by the state legislature in 1963. Since funds under this act became available in July, 1964, community interest and action have moved forward dramatically.

During the first full year of operation 25 counties, with 79 per cent of the state's population, have elected to proceed under the act through the appointment of official boards or study committees. Eighteen of these counties and the city of Detroit, with more than 60 per cent of the state population, have established mental health boards either singly or in combination with other counties.

Seven boards have submitted plans and budgets to the Department of Mental Health and all have been approved to receive matching funds during 1965-66. The state legislature has appropriated $2,500,000 for matching purposes during the next fiscal year. Funds from other local sources, such as community chests, may be used for matching purposes.

Counties may appropriate from general tax funds or may adopt special tax millage for support of the programs.

Under this act the Department of Mental Health may make matching grants to assist any county or combination of counties, or the city of Detroit, in establishment and operation of local mental health programs. The community program must include at least three of six basic services:

(a) Collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, mental retardation and other psychiatric disabilities.

(b) Information and education services to the general public, and lay and professional groups.

(c) Consultative services to courts, public schools, health and welfare agencies available to the public.

(d) Outpatient diagnostic and treatment services.

(e) Rehabilitative services for patients suffering from mental or emotional disorders, mental retardation and other psychiatric conditions particularly those who have received prior treatment in an inpatient facility.

(f) Inpatient diagnostic and treatment services.

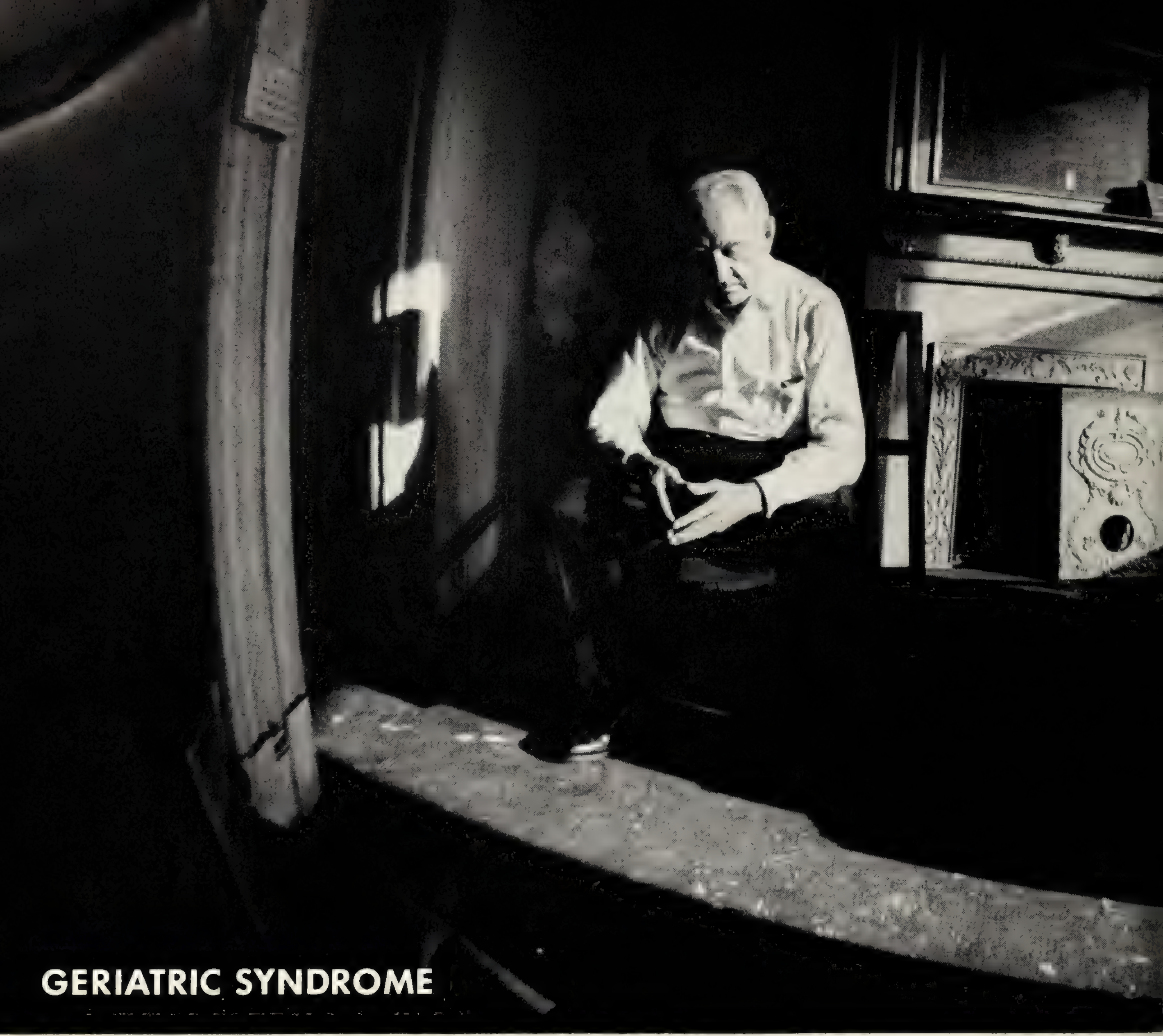
One of the major criteria for receiving state funds is the development of new services or the expansion of already existing community services for the mentally ill, mentally retarded or emotionally disturbed.

Development or expansion of psychiatric services in local general hospitals is encouraged.

Although no funds for facilities are provided under the state act, federal legislation adopted during the current session of Congress offers assistance to communities in the construction of mental retardation facilities and community mental health centers.

Counties now providing services under the act are: Bay, Baraga-Keweenaw-Houghton-Ontonagon, Detroit-Wayne, Dickinson-Iron, Ingham, Oakland and Shiawassee.

When the act was passed there was some apprehension that less populated counties would not be in a position to develop acceptable plans. This has not proven to be the case. Seven counties in two areas of the Upper Peninsula are operating under provisions of the act, and Shiawassee county (56,000) was the first plan approved by the department.



when a change in environment overwhelms him with anxiety

Failing health, financial difficulties, or the death of a spouse are among the reasons why elderly people may be obliged to leave their familiar surroundings. Moving in with children or entering a home for the aged may satisfy practical requirements but can be psychologically traumatic since emotional resilience tends to diminish with age.

Even when anxiety reaches overwhelming proportions, you can counteract it promptly with the potent tranquilizer—Atarax (hydroxyzine HCl).

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No age, of course, is exempt from anxiety and any number of circumstances can unleash it. Keep Atarax in mind for *all* your emotionally distressed patients—from under 6 to over 60.

for any age—for any stage of anxiety

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Side effects and precautions: The transitory drowsiness which may occur with hydroxyzine HCl usually disappears spontaneously in a few days with continued therapy, or is correctable by dosage reduction. Dryness of the mouth may be seen with higher doses. Involuntary motor activity has been reported in hospitalized patients on higher than recommended doses. Hydroxyzine HCl may potentiate CNS depressants, narcotics such as meperidine, barbiturates, and anticoagulants. In conjunctive use, dosage for these drugs should be decreased. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. **Parenteral Solution Precautions and contraindications:** This dosage form is intended only for I.M. or I.V. administration and should not, under any circumstances, be injected subcutaneously or intra-arterially. When the usual precautions for I.M. injection have been followed, reports of soft tissue reactions have been rare. I.V. administration should be slow, no faster than 25 mg. per minute, and should not exceed 100 mg. in any single dose. Particular care should be used to insure injection only into intact veins; a few instances of digital gangrene occurring distal to the injection site have been attributed to inadvertent intraarterial injection or periarterial extravasation, both of which should be avoided. **More detailed professional information available on request.**

Federal Grant to Help Erect New U-M Building

The University of Michigan has received a grant of $2,545,000 from the Federal Government to help finance construction of a new medical science building.

Making the grant was the National Institutes of Health, Public Health Service, and U. S. Department of Health, Education and Welfare.

The Health Research Facilities construction grant will provide a research wing addition to the main structure of the new medical science building. The state of Michigan previously approved $9,400,000 for the second medical science building to be constructed on campus in recent years. The first unit was completed in 1958.

Construction of the second unit will bring all medical school departments to the medical center for the first time. The new building also will provide instructional facilities to meet increased enrollment needs, and provide space for faculty and student research.

New Study to Survey Health Needs

Approximately 300 Michigan citizens—representative of all elements of the community—are being selected and organized by the Michigan Community Health Services Study into six regional groups and one state-wide group during the next several months.

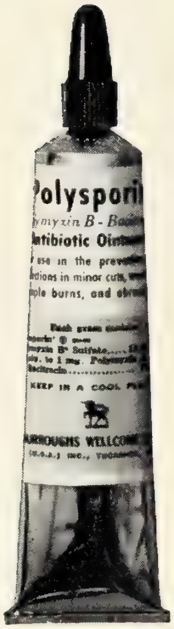
The groups will have two broad tasks, according to the study officials, "to assess the health needs of the region and the state, and to recommend changes necessary for the efficient development of health services to meet these needs." The medical profession will be represented as one of 16 segments of the community.

The three-year study is financed through grants from the W. K. Kellogg Foundation and the United States Public Health Services, and is sponsored and coordinated by the Michigan Health Officers Association, the Michigan Department of Health and the University of Michigan School of Public Health.

Director of the professional staff is Vlado A. Getting, M.D., of U-M.

> *"We do not maintain freedom in order to permit eccentricity to flourish; we maintain freedom in order that society may profit from criticism, even eccentric criticism . . . we encourage dissent because we cannot live without it."*
>
> —HENRY STEELE COMMAGER

in treating topical infections, no need to sensitize the patient



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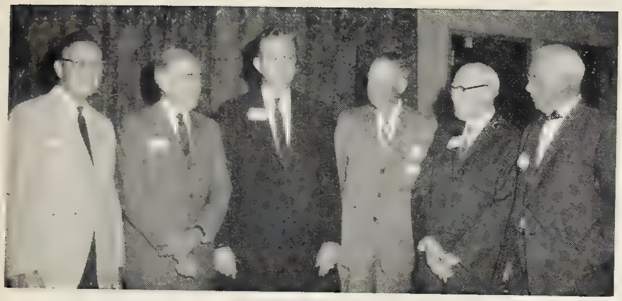

More than 300 physicians and wives participated in the 45th Annual Coller-Penberthy-Thirlby Medical Conference at Traverse City. Among the dignitaries on the program were, left to right, A. James French, M.D., Ann Arbor, co-chairman for the conference; H. Gordon Scott, Ph.D., Wayne State University; Dean William N. Hubbard, M.D., University of Michigan; George C. Adie, M.D., New Rochelle, N. Y.; Dean Emeritus Albert C. Furstenberg, M.D., University of Michigan, and Carl A. Badgley, M.D., Ann Arbor.

MHA Prepares New Reference Cards on Stroke

A set of medical desk reference cards on stroke is now available to any interested physician—just write to the Michigan Heart Association, 13100 Puritan, Detroit 48227, or phone 342-2100.

The set, the first of its type in Michigan, consists of 14 cards, 4″ x 6″, printed on both sides. It covers seven topics: Differential Diagnosis of Stroke, Cerebral Thrombosis, Intracerebral Hemorrhage, Transient Ischemic Attacks, Cerebral Embolism, Subdural Hematoma, Subarachnoid Hemorrhage, Directions for Hemiplegic Sling, Rehabilitation of the Stroke Patient. Additional cards on rehabilitation techniques are now under preparation and will be delivered later.

The cards were written in semi-outline form by the Stroke Committee of the Heart Association, chaired first by Michael C. Kozonis, M.D., Pontiac, and later by Frederic B. House, M.D., Ann Arbor.

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Not all patients are so lucky as to have retired to Florida, where they can pick citrus fruit off their own trees. But any patient anywhere can get the same benefits of the natural vitamin C in Florida oranges, grapefruit, and tangerines . . . thanks to modern methods of processing fresh fruit. Whether it is frozen, canned, or in cartons, 98% of the vitamin C content of the fruit is preserved.

Grapefruit and other citrus fruits filled with vitamin C are valuable in the nutrition of every age group. Among the teen-agers, vitamin C is one of the two nutrients most often low in the diet. Infants, too, need generous amounts of vitamin C; and they will take it readily when it comes to them in the form of delicious orange juice.

When your patient chooses *Florida* citrus, he can be sure of getting fruit filled with natural goodness and of just the right sweetness. Florida citrus is unexcelled because a State commission watches over the entire Florida citrus crop to see that it meets the world's highest standards for fresh, frozen, canned, or cartoned citrus fruit.

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DOCTOR HURON IS NEW U.P. PRESIDENT

MSMS President McGillicuddy was one of the speakers at the annual meeting of the Upper Peninsula Medical Society.

Held this year at Marquette, the event drew more than 200 physicians and wives. Matthew C. Bennett, M.D., Marquette, president of the Marquette-Alger County Medical Society, presided in his capacity as president also of the UP group.

The next president will be Willis H. Huron, M.D., Iron Mountain, a former MSMS Councilor.

Marquette area physicians who were chairmen for different aspects of the 72nd annual meeting were E. R. Huffman, M.D., program; J. W. Lyons, M.D., registration; G. M. Wilson, M.D., housing; J. R. Acocks, M.D., exhibits; W. C. Humphrey, M.D., finance, and T. B. Bolitho, M.D., publicity.

The speakers at the scientific portions of the meeting included J. Robert Willson, M.D., David G. Anderson, M.D., Robert D. Johnson, M.D., all of Ann Arbor; Robert E. Berry, M.D., Flint; W. W. Jack, M.D., Grand Rapids and Gerald M. Breneman, M.D., and Frank Cox, Jr., M.D., both of Detroit.

Other speakers included Sidney Adler, M.D., Detroit, president of Michigan Medical Service.

The Auxiliary program featured an address by Mrs. Milton R. Weed, of Grosse Pointe Park, president of the state Auxiliary to MSMS.

WSU Plans Symposium On "Mother and Fetus"

A symposium on "Mother and Fetus" will be presented by the Harper Hospital Department of Obstetrics and Gynecology and Wayne State University School of Medicine on November 10-11. The symposium on reproductive physiology and pathology will be held at the Harper Hospital.

Harold C. Mack, M.D., Chairman, reports that invitations to speak have been extended to Doctors Virginia Apgar, S. J. Behrman, Paul D. Bruns, Nicholson J. Eastman, John W. Greene, Jr., L. Mastroianni, Jr., George W. Mitchell, Ernest W. Page, Harry Prystowsky, Kenneth J. Ryan and James G. Wilson.

Beg Pardon

An article in the August issue inadvertently reported that Mrs. Henry Scovill, Ypsilanti, would become president of the Woman's Auxiliary to MSMS for 1965-1966. Mrs. Rufus Reitzel of Mt. Clemens is the President-Elect and will be installed at the Detroit convention. Mrs. Scovill is the First Vice-President now.

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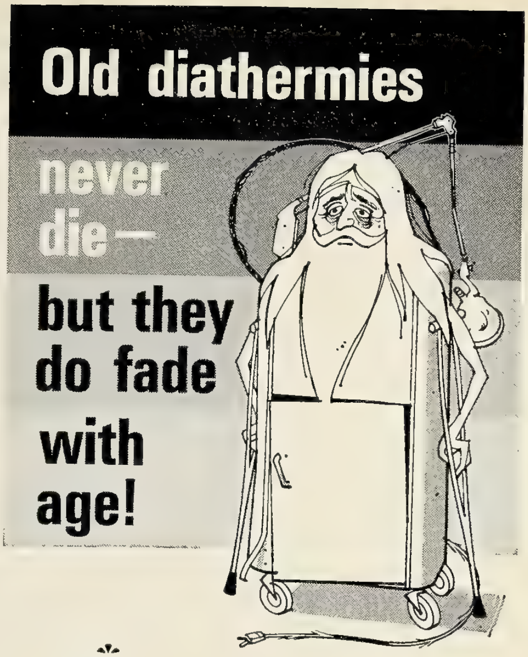

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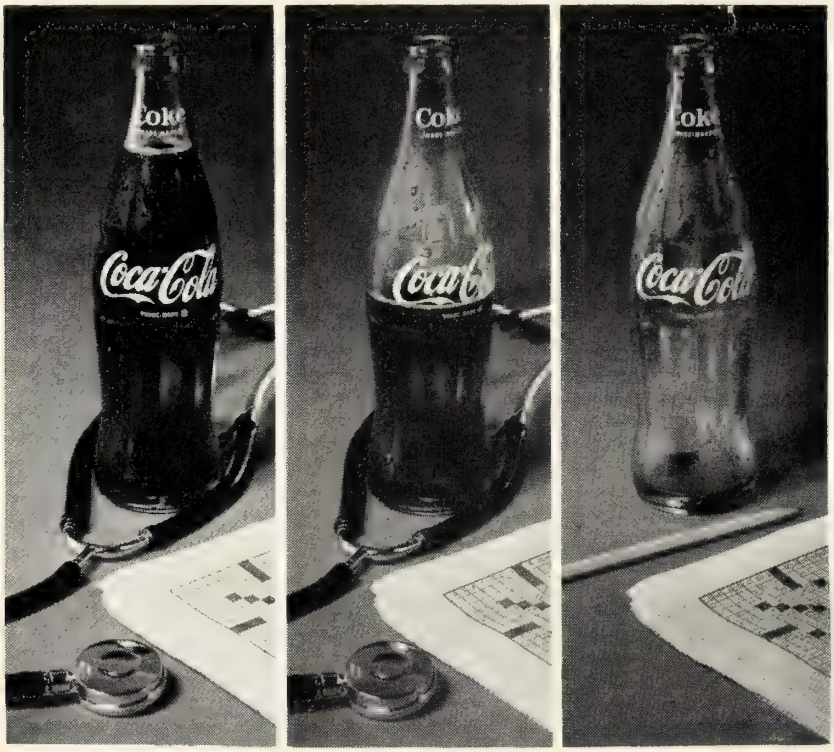
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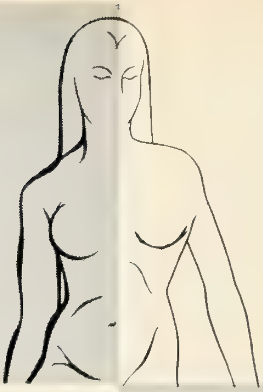

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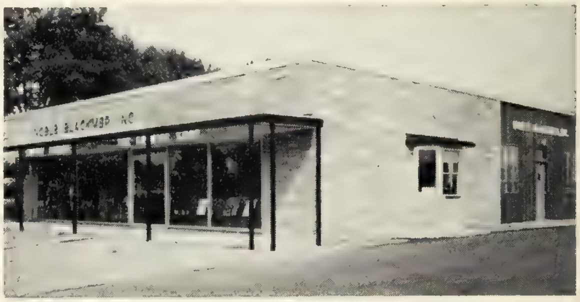

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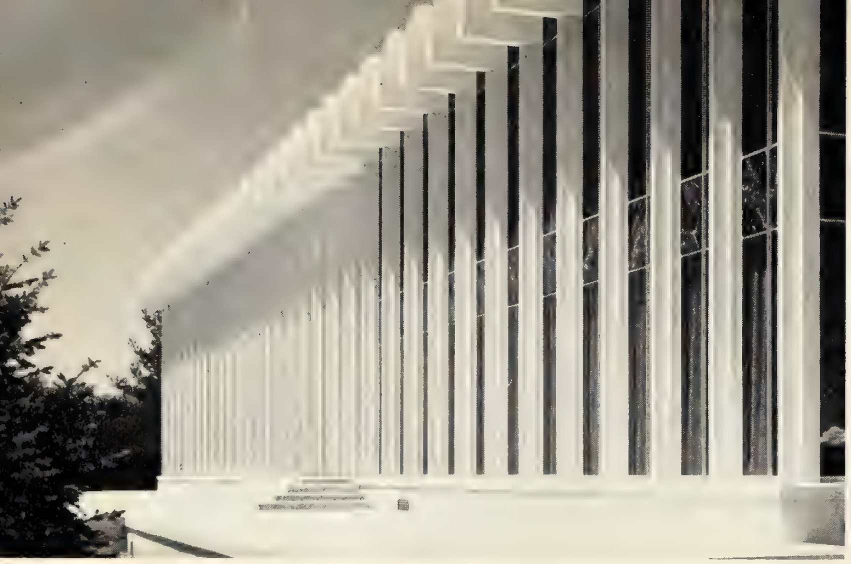

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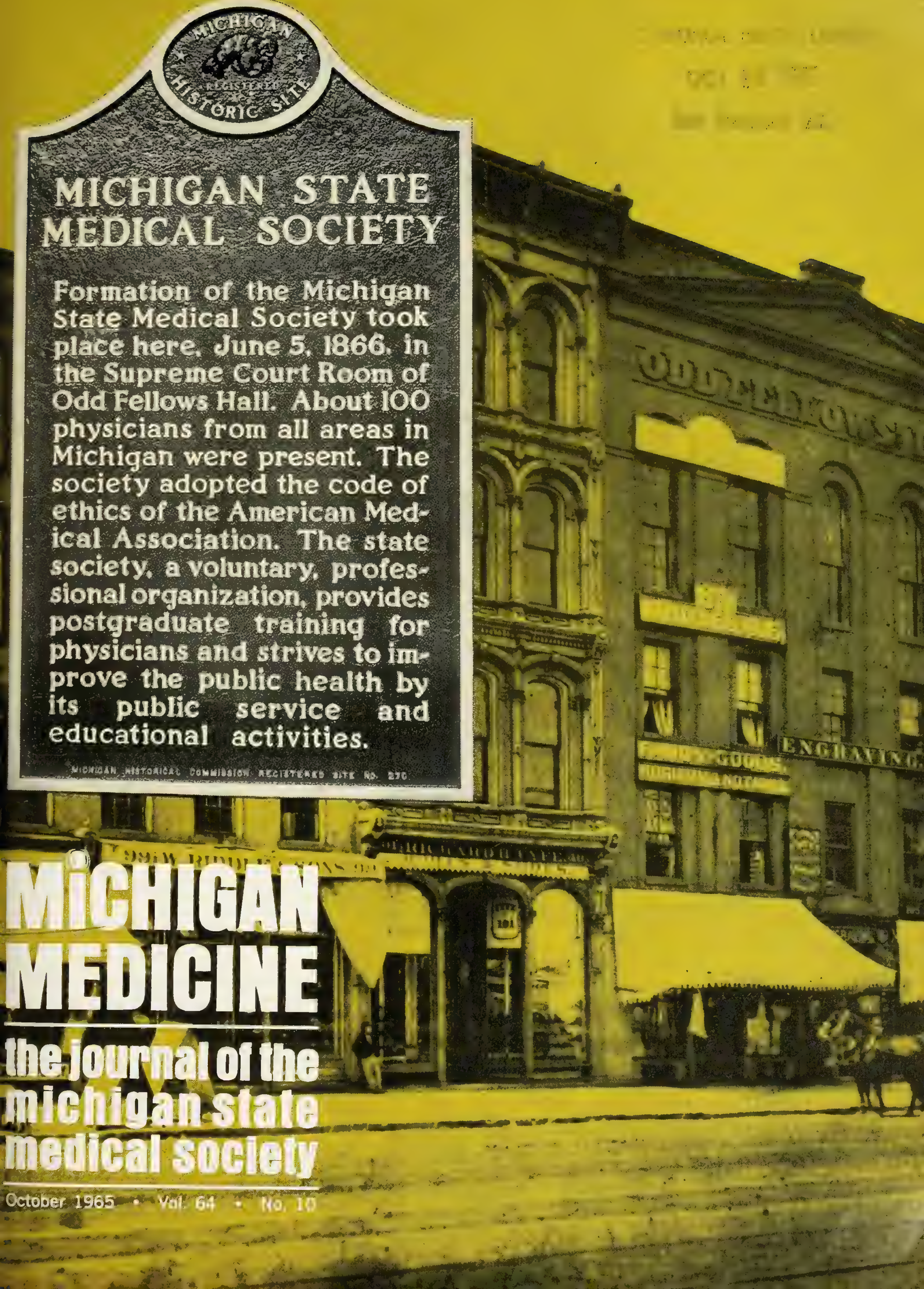

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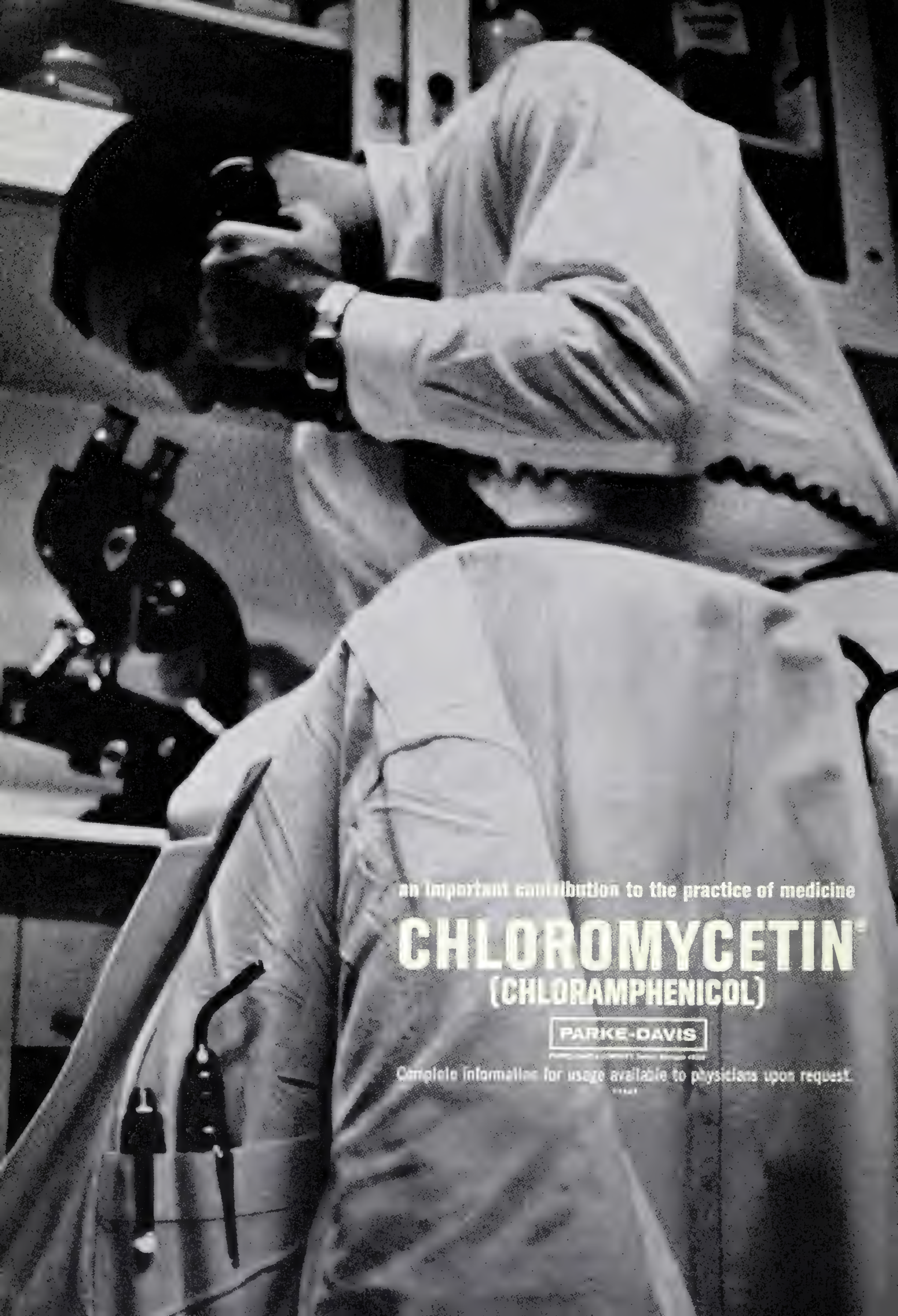
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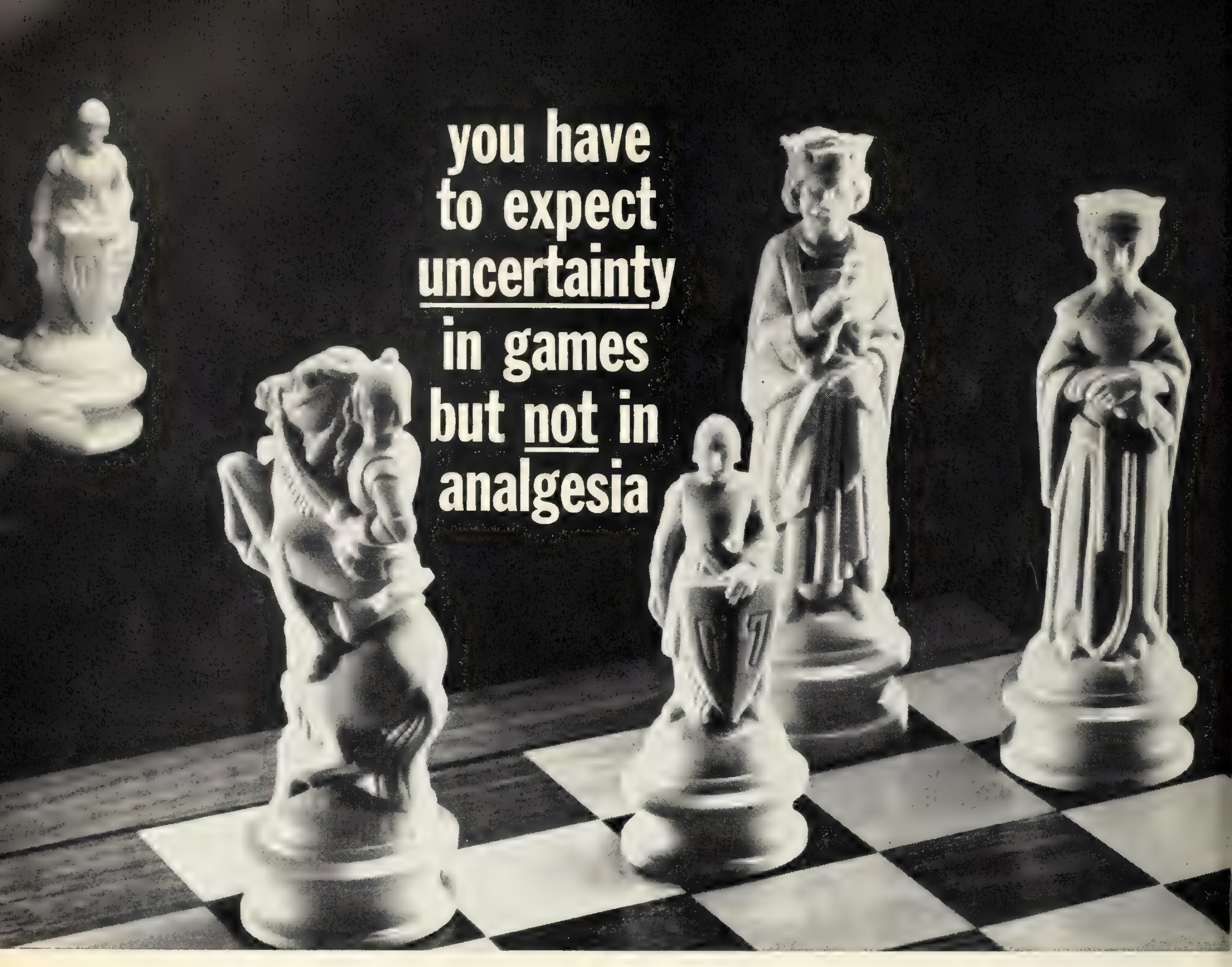

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MICHIGAN MEDICINE

October, 1965 • Vol. 64 • No. 10

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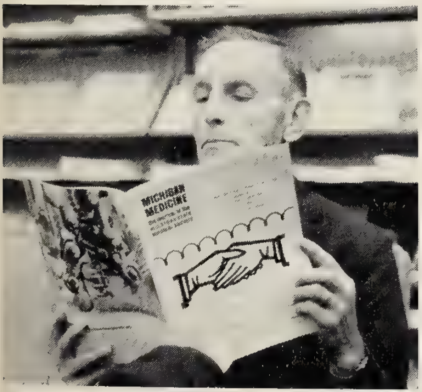

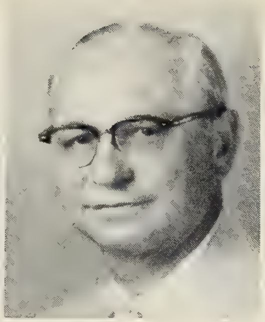

the president's message . . .

Interesting, ambitious plans for the Michigan State Medical Society—for the county societies—and for every member, too—were adopted by the MSMS House of Delegates in Detroit during the Centennial Session.

The Delegates took action on the many resolutions and committee reports to decide on various policy matters for the state society.

In many cases, the Delegates decided on the direction of various projects and programs for MSMS.

The Delegates also respectfully recommended several projects to the component county medical societies.

And some of the resolutions relate to each member, and thus offer individual challenges.

But . . . what happens now depends upon each individual member.

My recommendations on ways to build upon the work of the 1965 House of Delegates may not be new, but this month they merit reconsideration. I would make these earnest appeals to each member of MSMS:

1. Decide today to be a more active member of your County Society and MSMS, and the AMA, too.

2. Make every effort to attend your component society and state meetings regularly, and to take part in the discussions.

3. Participate in at least one of your component society committees, and make it function effectively.

4. Accept positions of leadership. If you are a committee chairman or officer, strive to rally others to work together willingly. Assist the members in charting a course, and in moving towards the goals of both public and professional service.

5. Evaluate the work of your county and state societies. These organizations are yours, so voice your concerns and interests.

The Centennial Session in Detroit—the biggest meeting ever for MSMS—has set some new patterns for medicine in Michigan. The Centennial theme of "A Century of Service in Medicine" presents challenges for each of us individually, for each of 55 component societies and for the MSMS.

During this Centennial year, we should listen to the echos of excellence. Let us build on the good foundation and dedicate ourselves in a second century of service to the highest goals of the medical profession.

Luther R. Leader, M.D.

The good life—just what the doctor ordered

Sea and sun are both in his doctor's orders — so is that grapefruit he's eating with such gusto. Citrus fruit is a wonderful way for this patient or any patient to get his daily quota of vitamin C . . . to enjoy something good to eat, tasty and satisfying but not rich.

Not all patients are so lucky as to have retired to Florida, where they can pick citrus fruit off their own trees. But any patient anywhere can get the same benefits of the natural vitamin C in Florida oranges, grapefruit, and tangerines . . . thanks to modern methods of processing fresh fruit. Whether it is frozen, canned, or in cartons, 98% of the vitamin C content of the fruit is preserved.

Grapefruit and other citrus fruits filled with vitamin C are valuable in the nutrition of every age group. Among the teen-agers, vitamin C is one of the two nutrients most often low in the diet. Infants, too, need generous amounts of vitamin C; and they will take it readily when it comes to them in the form of delicious orange juice.

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Dosage: 1 to 3 capsules daily. **Side Effects:** Gastrointestinal, occurring more often at higher dosage levels, abate promptly upon dosage reduction or temporary withdrawal. **Precautions:** Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis which is accompanied by acidosis, and treated accordingly. Lactic acidosis has been reported in nondiabetics and diabetics treated with insulin, with diet, and with DBI. Question has arisen regarding possible contribution of DBI to lactic acidosis in patients with renal impairment and azotemia and also those with severe hypotension secondary to myocardial or bowel infarction. Periodic B. U. N. determinations should be made when DBI is administered in the presence of chronic renal disease. DBI should not be used when there is significant azotemia. Any cardiovascular lesion that could result in severe or sustained hypotension, which may itself lead to development of lactic acidosis, should be considered cause for immediate discontinuation of DBI at least until normal blood pressure has been restored and is maintained without vasopressors. Should lactic acidosis occur from any cause, vigorous attempts should be made to correct circulatory collapse, tissue hypoxia, and pH. **Contraindications:** Severe hepatic disease, renal disease with uremia, cardiovascular collapse. Not recommended without insulin in acute complications of diabetes (metabolic acidosis, coma, severe infections, gangrene, surgery). **Pregnancy Warning:** *During pregnancy, until safety is proved, use of DBI like other oral hypoglycemic drugs, is to be avoided.*

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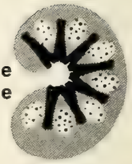

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Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

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References: (1) Carroll, G.: Urologists' Letter Club, June 1, 1964. (2) McDonald, D. F., and Short, H. B.: Address to the Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, New York, Oct. 26-28, 1964.

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*of a total of 1049 patients treated (Cooperative Study, Department of Medical Research, Winthrop Lab.)

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ADVICE TO AUTHORS:

1. Address scientific manuscripts to Editor, Michigan Medicine, C. J. Tupper, M.D., 2490 Adare, Ann Arbor, Michigan.
2. Submit original, double-spaced typewritten copy and one carbon copy on letter size (8½ x 11 inch) paper.
3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.
4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.
5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by The Journal. The Journal will pay the first $25 of the engraving bill, and the author shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.
6. References will ordinarily be limited to seven in number. Exceptions may occassionally be made.
7. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.
8. Articles should ordinarily be less than four printed pages in length (3000 words).
9. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.
10. Specify address to which galley proof should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.
11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.
12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

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We would like to continue our subscription to MICHIGAN MEDICINE. We also wish to congratulate you on the revised format of the journal—it is most excellent.

FRED I. CHASE, *Executive Director*
Michigan State Podiatry Association

Enclosed is our check to cover my subscription to MICHIGAN MEDICINE. I should also like to take this opportunity to compliment you on its new format and excellent contents.

J. E. VERBIEST, *Director*
Professional Relations
Michigan Medical Service

Please forward a copy of the Analysis of Social Security Amendments for 1965. This was offered in the July Medigram.

I appreciate the Medigram very much. Keep up the good work.

RICHARD S. KNOX, M.D.
Royal Oak, Michigan

On this morning's NBC TV's Today show, a general practitioner in a surgical gown with his back to the audience was knocking internship and the medical profession generally from his individual experience. In this manner his unsigned book "Interne" was promoted. Since the AMA hasn't objected yet, though it may not have read any of the 25,000 copies already sold, he claims merit for his book.

To say his intern training is universal would require training in every hospital in the country. Such training varies as the content of hospital facilities and the special interests of the doctors attending. Nor can every hospital be a university hospital. Since events are never identical for each intern, training is as varied as the number of interns.

In the same hospital and with the same doctors, some interns may get a great deal and a rare one very little. Some individuals require longer to mature. If he was a sophomorish sorehead, he may have gotten very little, as that type generally does. One would like to know how his residents and fellow interns evaluated his performance. Those with genuine effort and sincerity do learn, even under adverse conditions if any. Was this book his expiation?

While it may be tremendously shocking to a TV commentator to discover that an intern at the start of training may not know exact dosages, it is far more important that in medical school he learned the action of drugs. Also it's a virtue to look up details rather than to depend on hearsay or even guess. This trait of verifying is too commonly lacking among laymen.

He advocates periodic re-examination in medicine to check doctors. How practical and of what value would it be to physicians that they have limited their field as in psychiatry, dermatology, anesthesiology, etc.? In concentrating on their specialty, they neither have the time nor the energy to stray so far afield. In time if they should refuse, then they would further compound the problems of a doctor shortage. Anyway in outlying communities, a doctor 60 per cent up-to-date is better than none. Unlike the researching professor, sitting in holy judgment, he isn't favored with a retinue of residents to free him from unavoidable scut work. So he is a berated front-line soldier often awaiting from researchers better methods that time won't dishonor again.

To write a book for laymen, who are not medical peers, is a disservice to the medical profession. It can only be sensational as are the non-representative spectacular movies sent overseas which don't portray the average American. Besides, anyone may make a lucky diagnosis, yet a doctor is required to decide when history and symptoms are inexact or incomplete. So the book may have been written by a sophomorish sorehead or one that wishes to exploit the liberal trend to knock the profession. Renegades can always be found to popularize causes. Perhaps he's in training to become a bureaucrat, who goes about half-cocked.

Sincerely,
STEPHEN MALINA, M.D.

On July 15 the so-called "Drug Abuse Control Amendments" . . . originally inspired by Senator Dodd of Connecticut and introduced by Representative Oren Harris of Arkansas . . . became law. This Bill, *whose provisions are to take effect February, 1966*, is designed to control illicit traffic, interstate and intrastate, in amphetamines and barbituates (and other drugs which may be found to have similar effects on the central nervous system) and to stem the abuse arising from this traffic.

The Harris Bill should do much to ameliorate an undesirable situation. It is, in our opinion, a moderate and sensible bill. It provides that manufacturers, wholesalers and retailers must keep accurate records of all purchases and dispositions of the controlled drugs for three years. It in no way affects the physician's freedom of practice except as regards these two provisions:

1. Refills by the pharmacist of prescriptions for the drugs covered are limited to five in a period of six months. However, when a prescription expires, you may authorize its renewal, orally or in writing.
2. Physicians who regularly dispense these drugs and charge for them must keep accurate records of all purchases and dispositions of same for three years.

The American Medical Association and the Pharmaceutical Manufacturers Association both supported the bill.

We are writing this letter to make it clear how the new law affects your practice, and to call to your attention S K & F's positive position on this legislation.

Sincerely,
Walter A. Munns, *President*
Smith, Kline & French Laboratories

Following is a notice of our Medical-Dental Meeting for 1966. Your favorable consideration again will be deeply appreciated. Reservation commitments are expected by September 1, so if possible, an early "premature" listing will be most helpful.

Canadian-American Medical-Dental Ski Association (CAMDSA), 6th Annual Meeting, February 6-13, 1966, The Lodge at Vail, Colorado.

Secretary-Treasurer, T. J. Trapasso, M.D., 816 Ashmun Street, Sault Ste. Marie, Michigan.

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"The physician is particularly vulnerable because he was worked hard, is not lazy, and all day long has been 'giving' to his patients. So, it is understandable that he should come home expecting to have his virtue rewarded, in some degree, by his wife and family.

"Yet, all his good acts on behalf of his patients (which, he must admit, give him considerable satisfaction) haven't benefited his wife one bit. She, as much as any other woman, needs some of the care and concern that her husband so lavishly hands out to his patients."—A. S. Norris, M.D.; The Tired Mother, *J. Iowa Med. So.*, August, 1964.

Doctor . . .
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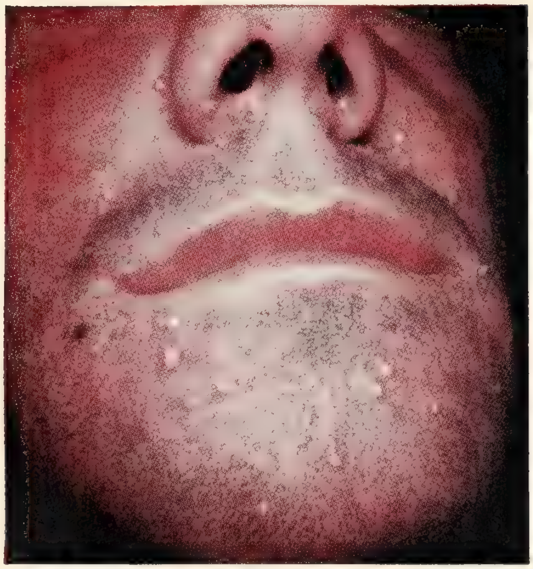

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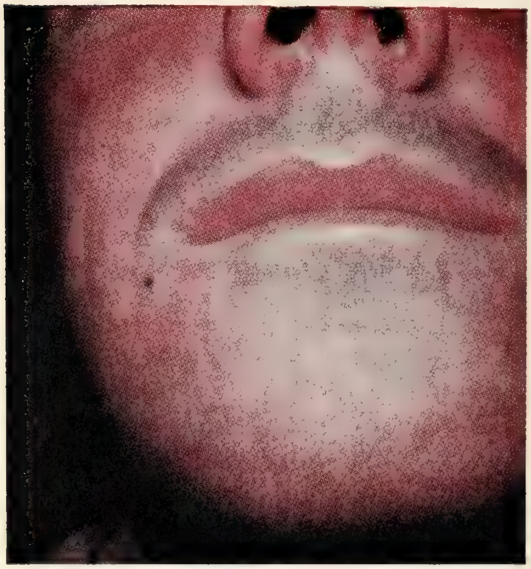

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IN MEMORIAM

JOSEPH C. GEMEROY, M.D.

Joseph C. Gemeroy, M.D., 63, Detroit ophthalmic surgeon, died September 1 at his residence in Pleasant Ridge.

A native of Winchester, Ontario, Doctor Gemeroy was graduated from McGill University Medical School in Montreal. He served his eye residence at Ford Hospital and was associated with that hospital until 1943.

Doctor McNabb was chief of ophthalmology at Woman's Hospital, Detroit, and on the staff at Children's and Beaumont Hospitals. He also served as an assistant professor of ophthalmology at Wayne State University.

A governor of the American College of Surgeons, Doctor Gemeroy was a past president of the Detroit Ophthalmic Society and the Detroit Ophthalmology Club.

LOUIS GROSS, M.D.

Louis Gross, M.D., 53, Detroit physician, died August 20 at Harper Hospital.

Doctor Gross, a lifelong resident of Detroit, received his medical degree from Wayne State University School of Medicine in 1934. He was a member of the staffs of Holy Cross and Saratoga Hospitals. Active in the Jewish Parents Institute, Doctor Gross was a member of Phi Lambda Kappa medical fraternity.

Doctor Gross practiced medicine in Detroit for 30 years.

LEO J. KENNEY, M.D.

Leo J. Kenney, M.D., 48, prominent Grand Rapids heart surgeon, died August 28 at Henry Ford Hospital in Detroit, where he was a thoracic and cardiovascular surgeon from 1951 to 1956.

A native of Lowell, Mass., Doctor Kenney received his B.S. degree at Villanova University in Philadelphia and studied general surgery and thoracic and cardiovascular surgery at Tufts University and affiliated hospitals in Boston.

Doctor Kenney was senior thoracic surgeon at Butterworth Hospital and St. Mary's Hospital, Grand Rapids. He was a consultant in thoracic surgery at Blodgett Memorial Hospital, Sunshine Hospital, Ferguson-Droste-Ferguson Hospital and Mary Free Bed Hospital in Grand Rapids and at Zeeland Hospital, Holland Hospital and Kelsey Hospital in Lakeview.

Doctor Kenney's professional memberships included the American Association of Thoracic Surgeons, the Society of Thoracic Surgeons, the Pan Pacific Surgical Association, the American Board of General Surgery and the American Board of Thoracic Surgery. Doctor Kenney authored many articles on his specialty.

Doctor Kenney was a member of the House of Delegates of the Michigan State Medical Society.

ARTHUR A. McNABB, M.D.

Arthur A. McNabb, M.D., 75, Southwest Michigan physician for more than 40 years, died August 19 at Community Hospital, Watervliet.

Born at Elkton, Doctor McNabb was a graduate of Wayne State University School of Medicine. Doctor McNabb practiced in Lawrence, Michigan, and later practiced in Kalamazoo. He practiced in Watervliet for 20 years.

Doctor McNabb was on the staff of Community Hospital in Watervliet and Mercy Hospital in Benton Harbor. Doctor McNabb's memberships included the American Society of Anesthesiologists and the Michigan Society of Anasthesiologists.

A veteran of World War I, Doctor McNabb's survivors include William J. McNabb, M.D., of Chicago.

Doctor McNabb was a Life Member of the Michigan State Medical Society.

LEON E. PANGBURN, M.D.

Leon E. Pangburn, M.D., 78, Highland Park physician for 45 years, died August 16, at Highland Park General Hospital where he was a member of the staff.

A native of Arkansas City, Arkansas, Doctor Pangburn received his medical degree from the Eclectic Medical College in Ohio in 1917. Doctor Pangburn received his premedical training at the University of Cincinnati.

During World War I Doctor Pangburn served as a first lieutenant in the Medical Corps.

Doctor Pangburn was a Life Member of the Michigan State Medical Society.

ISAAC C. PREVETTE, M.D.

Isaac C. Prevette, M.D., long-time Pontiac physician and Oakland County Deputy Coroner, died August 8, 1965, three days short of his 73rd birthday.

Born in Wilkesboro, North Carolina, Doctor Prevette received his medical degree at the University of New York City and interned at Bellevue Hospital. Doctor Prevette took postgraduate studies at Rush Medical College and Cook County Hospital, Chicago, in gynecological surgery.

Doctor Prevette was in private pratice for 46 years and served 18 years as a coroner and medical examiner. His hospital affiliations included Pontiac General and St. Joseph Mercy, Pontiac. Doctor Pre-

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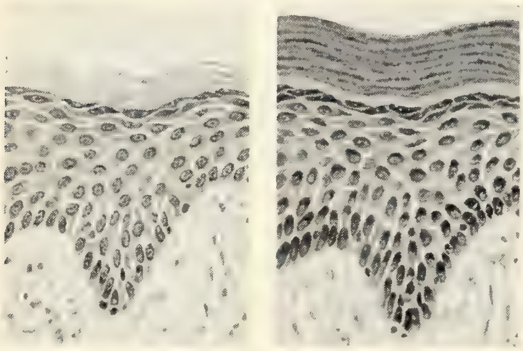

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vette was a past secretary-treasurer of the Oakland County Medical Society.

During World War I, Doctor Prevette held the rank of first lieutenant in the U.S. Army.

Doctor Prevette was a Life Member of the Michigan State Medical Society.

RAY V. TUBBS, M.D.

Ray V. Tubbs, M.D., 69, Blissfield, general practitioner for 33 years, died August 10.

A native of Adrian, Doctor Tubbs settled in Blissfield in 1932 and served as health officer for both the village and the township many years. In 1922 Doctor Tubbs was awarded a master's degree in research science from the University of California. He received his medical degree from the University of Michigan School of Medicine. Doctor Tubbs interned at Toledo Hospital and served a term as chief of staff at Bixby Hospital during his years of association with the Adrian institution.

Doctor Tubbs was a veteran of World War I, and an Associate Member of the Michigan State Medical Society.

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ADDENDUM

The authors of an article in the August issue of Michigan Medicine on "Acyanotic Heart Disease in Infancy" by Doctors G. C. Timmis, S. Gordon, L. Jacobson and P. Jordan present the following addendum:

"Since the preparation of the paper, Herbert Sloan, M.D., has reported the successful definitive repair of ventricular septal defects in 13 of 15 children less than six months of age, utilizing extracorporeal circulation." Doctor Sloan presented a paper "Extracorporeal Circulation in Infants" at the International Symposium on the Heart and Circulation in the Newborn and Infant, Chicago Heart Association, March 25-27, 1965.

The authors also report that the data used in their Michigan Medicine article were accumulated from June 1, 1960 to December 31, 1963, rather than from 1961 to 1963.

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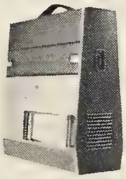

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NEWS BRIEFS

William D. Robinson, M.D., Ann Arbor, will discuss "Nutrition in Medical Education" at the Western Hemisphere Nutrition Congress, sponsored by the AMA in Chicago, November 8-11.

Robert I. Jaslow, M.D., Northville, has left his position as superintendent of the Plymouth State Home and Training School to become chief of the mental retardation branch, division of chronic diseases, U. S. Public Health Service, Washington, D. C.

The National Association of Blue Shield Plans has appointed **Tom K. Mura** as the director of its communications division. A graduate of Western Michigan University, Mr. Mura had served as assistant to the director of the American Medical Association's Communications Division.

Two Jackson County medical assistants—**Mary Hutchins** and **Gertrude Russell**—have received their certificates at the end of the inservice training educational program, which extended over six courses.

Lynn D. Eagles has been assigned to the Saginaw territory as a professional service representative for Smith Kline & French Laboratories. Formerly with Saginaw Steering Gear, Mr. Eagles is a graduate of Ferris State College.

Persons traveling abroad who require protection against yellow fever may now obtain the vaccine at the Ingham County Health Department office, 119 West Washtenaw St., Lansing. To do so an appointment must be made in advance. A fee will be charged for the vaccine and service.

The circulation of "The University of Michigan Medical Center Journal" has jumped to 15,500 with free distribution to all MSMS members. The Journal, published six times a year, contains scientific articles and news of the Medical Center, the faculty and alumni.

A catalog of more than 300 one-hour tape records, devoted to comprehensive discussions of everyday office problems by leading specialists, has just been released by the Audio-Digest Foundation, Los Angeles. A copy is available free of charge from the Audio-Digest Foundation, Editorial Offices, 619 South Westlake Avenue, Los Angeles 90057.

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References: 1. Goldsmith, J. W.: Minn. Med. (Feb.) 1957. 2. Groskloss, H. H., Clancy, C. L., Healey, E. F., McCann, W. J., Maloney, F. D., Loritz, A. F.: Clinical Medicine (Sept.) 1955. 3. Codling, J. W., Lowden, R. J.: Northwest Med. (March) 1958. 4. Bethea, R. C.: International Record of Med. (May) 1960. 5. Lenz, W., Second International Conference on Congenital Malformations, N. Y., N. Y., (July) 1963.

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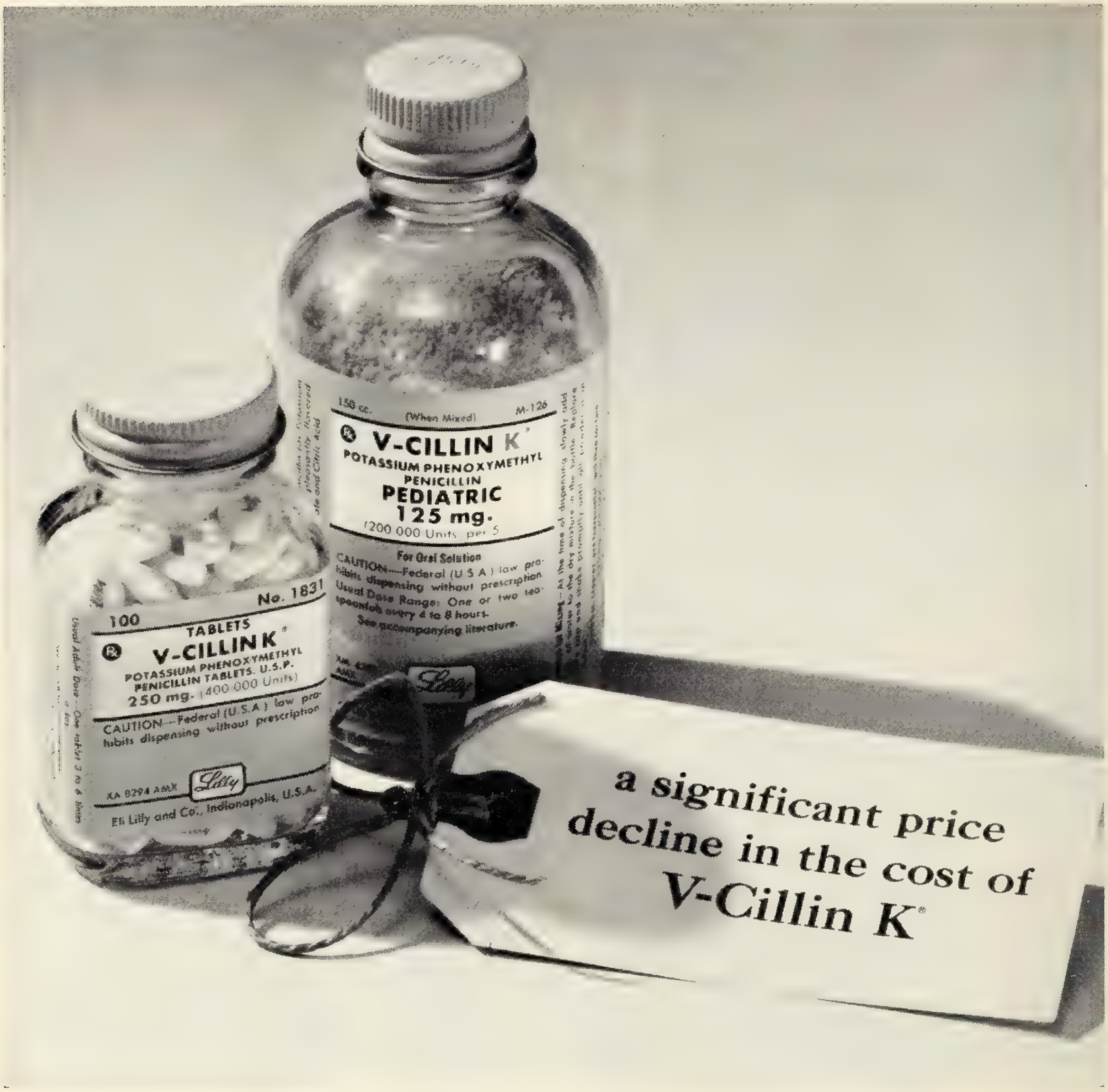
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Evaluation of Serum Enzyme Tests and Electrocardiographic Changes in Diagnosis of Acute Myocardial Infarction

By Ross V. Taylor, M.D.
Joseph A. Preston, M.D.
Both of Jackson

During the last decade there has been considerable interest and activity in the field of clinical enzymology. Our particular interest has been in the investigation of myocardial enzymes.

Measurement of enzyme activity in serum to confirm, and often to establish a diagnosis of myocardial infarction has become an increasingly important aid to the clinician. There have been numerous enzymes proposed as indicators of myocardial infarction.

Interest in the field started with the introduction of the measurement of serum glutamic oxalacetic transaminase (SGOT) by LaDue[1] in 1954. This was followed in order by lactic acid dehydrogenase (LDH),[2] alpha-hydroxybuterate dehydrogenase (HBD),[3] and most recently serum creatine phosphokinase (CPK).[4] None of these enzymes are limited to the myocardium alone.

There has been continual effort to arrive at organ specificity. The introduction of LDH isoenzymes[5,6] has been reported to fulfilling this need. In addition to the myriad of enzyme analyses there has been criticism of methodology. Amador[7] has raised the question as to the validity of the colorimetric assays and has proposed returning to the original ultraviolet methods for accuracy.

* * *

THESE conflicting data lead to our study. This report is the outgrowth of a two-year evaluation of multiple as well as serial determinations of serum glutamic oxalacetic transaminase, lactic acid dehydrogenase, serum alpha-hydroxybuterate dehydrogenase, serum creatine phosphokinase, and lactic acid dehydrogenase isoenzymes.

An attempt is made to select the best single measure or group of measures to be used in making or confirming the diagnosis of myocardial infarction. In addition, the colorimetric and spectrophotometric analyses are compared.

Material and Methods

A total of 26 patients are included in this study. All were admitted to the Mercy Hospital with a clinical diagnosis of acute myocardial infarction. Serial enzyme analyses were done from the day of admission to the hospital through the period of normalization of the enzymes under consideration. Analyses were done at 12-hour intervals for the first 48 hours of hospitalization, and subsequently at 24-hour intervals. A total of 2500 determinations were done and approximately 100 electrocardiograms were interpreted. The interpretations were those of a single electrocardiographer (R.V.T.).

The enzyme methods are shown in **Table I.** The colorimetric procedures were read on a Coleman Jr. spectrophotometer. The spectrophotometric methods were read on a Hitachi Perkin-Elmer, Model 139. All reagents used are commercially available.*

Results

Comparison of colorimetric and spectrophotometric methods—In all of the enzymes studied there was good correlation between the spectrophotometric and colorimetric analyses. They were not

SCIENTIFIC PAPERS

From the Departments of Medicine and Laboratories, Mercy Hospital, Jackson, Michigan.
Sponsored by a Grant-in-aid, Michigan Heart Association.
Presented in part before the 1964 Regional Meeting of the American College of Physicians, Hidden Valley, Mich.

*Sigma Chemical Company, St. Louis 18, Mo.
Calbiochem, P.O. Box 54282, Terminal Annex, Los Angeles 54, Calif.

TABLE I.

Enzyme	Method	Normal
SGOT	Colorimetric; Reitman and Frankel[8] Spectrophotometric; Karmen[9]	10-40 *
LDH	Colorimetric; Berger and Broida[10] Spectrophotometric; Wroblewski and LaDue[11]	100-500*
HBD	Colorimetric; Rosalki[12] Spectrophotometric; Rosalki and Wilkinson[13]	25-105**
CPK	Spectrophotometric; Tanzer and Gilvarg[14]	0-3 *
LDH Isoenzymes	Starch gel electrophoresis; Smithies[15] Cellulose acetate electrophoresis; Barnett[16]	

* Spectrophotometric units
**International units

always identical in value, but direction and magnitude of change was parallel throughout. The spectrophotometric analyses tend to be somewhat higher than the colorimetric. However, in no instance was there a gross disagreement in procedures. There were no false positives or negatives with either series of methods.

Serum glutamic oxalacetic transaminase—The SGOT began to rise approximately 12 hours post clinical onset of infarction. It reached a maximum of three to four times normal within 24 hours. Return to normal was usually complete by the third or fourth day post-infarction. Twenty-three of the 26 cases had abnormal SGOT levels.

Lactic acid dehydrogenase—The serum LDH began to rise between 12 and 24 hours post-infarction. It reached a peak of an average of 3.6 times normal value by the end of 72 hours and then gradually returned to normal within a period of 7 to 10 days. All LDH values were normalized by the tenth day. The rise of LDH followed the rise of SGOT by approximately 12 hours.

R. V. TAYLOR, M.D.

J. A. PRESTON, M.D.

Serum alpha-hydroxybuterate dehydrogenase—This enzyme was likewise elevated in all of the cases. Its rise paralleled that of LDH. It began to rise between 12 and 24 hours post-infarction, peaking at four to five times normal in 72 hours, and gradually returning to normal in from 10 to 15 days post-infarction.

Isoenzymes of lactic dehydrogenase—Lactic acid dehydrogenase is separated into five distinct fractions by the methods employed in this study. The patterns on cellulose acetate and starch gel were similar. The fractions migrating with the gamma globulin or slow moving fractions are characteristic of liver cell destruction. The fast-moving fractions, those migrating with the alpha-1 globulin and albumin were characteristic of myocardial LDH and erythrocytic LDH.

In all 26 cases there were abnormal isograms, all with characteristic increase in the fast moving components. This abnormality was noted as early as 12 hours post-infarction and in the more severe cases remained elevated for from 10 to 15 days. The LDH isogram more closely paralleled the HBD rise and fall.

Figure 1 illustrates a serial isogram in a single case from the onset of infarct through the normalization.

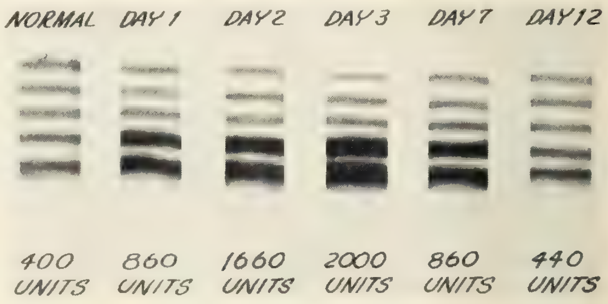

Fig. 1. Cellulose acetate LDH isogram prepared from serial samples of a single patient. The fast-moving fractions are at the lower portion of the isogram.

Creatine phosphokinase—Twelve of the 28 patients studied had abnormal creatine phosphokinase levels. The enzyme was abnormally elevated as early as three hours after the clinical onset of myocardial infarction. In eight of the 12 cases in which it was abnormal this enzyme was the first enzyme to rise. It reached its peak level of approximately 10 to 11 times normal value in from 30 to 36 hours post-infarction and fell percipitously to normal levels between 48 and 72 hours post-infarction.

Comparison of enzyme abnormalities and electrocardiographic changes—All 26 cases studied had abnormal serum enzyme levels diagnostic of, or

A study was undertaken to determine the comparative practical and diagnostic value in acute myocardial infarction of a group of enzyme determinations correlated with electrocardiographic findings. The enzyme determinations included transaminase (SGOT), lactic acid dehydrogenase (LDH), alpha-hydroxybuteric dehydrogenase (HBD), creatine phosphokinase (CPK), and LDH isoenzymes. Both spectrophotometric and colorimetric determinations were done simultaneously. Twenty-six patients were studied with serial assays.

A critical comparison of the enzymes as well as the methods is made. In addition, a correlation of electrocardiographic changes with enzyme abnormalities is presented. Recommendations are made as to the proper choice of enzyme to be used in establishing or confirming the diagnosis of myocardial infarction.

compatible with, a diagnosis of myocardial infarction. Nineteen of the 26 cases had diagnostic electrocardiograms during the course of the study. Of the seven cases which had non-diagnostic electrocardiograms, six tracings showed complete left bundle branch block. The seventh had minimal changes showing transient T-wave inversions of the chest leads. In eight of the cases the serum enzyme levels were abnormal prior to the development of a diagnostic electrocardiogram. In four of the cases the electrocardiogram was diagnostic prior to the abnormal elevation of one or all of the serum enzymes.

Illustrative Examples

Case No. 1—C.R., a 72-year-old white male, was admitted to the medical service one week following the clinical onset of myocardial infarction. One week prior to admission he suffered severe chest pain which subsided in 24 hours. He was admitted to the hospital free of pain, but with a chief complaint of weakness. His admitting electrocardiogram (**Figure 2**) showed a complete left bundle branch block. A definite diagnosis of myocardial infarction could not be made on this or subsequent tracings. **Table II** shows a summary of his initial enzyme studies. The SGOT and the CPK were within normal limits. However, the LDH and HBD were elevated, and the isoenzymes of LDH showed a fast-moving cardiac fraction confirming the clinical impression of myocardial infarction. The falling LDH and HBD in the presence of a normal SGOT and CPK would indicate that the infarct had occured several days prior to admission.

Case No. 2—F. W., a 65-year-old white male, was admitted to the hospital five hours prior to the onset of severe substernal pain. His admitting electrocardiogram was interpreted as being completely within normal limits. Subsequent tracings showed

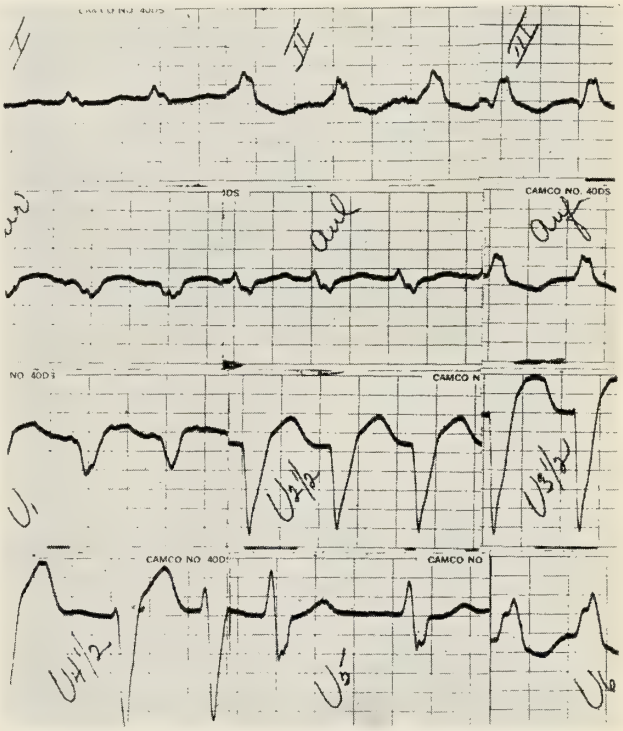

FIG. 2. Admitting EKG on Case No. 1

TABLE II.

Enzyme Profile on Case No. 1
C. R., 72-Year-Old Male, Admitted 11/27

	11/27	11/28	11/29	11/30
SGOT	16	14		
LDH	1080	960		
HBD		177	142	120
CPK	0	0		
ISO	POS	POS		

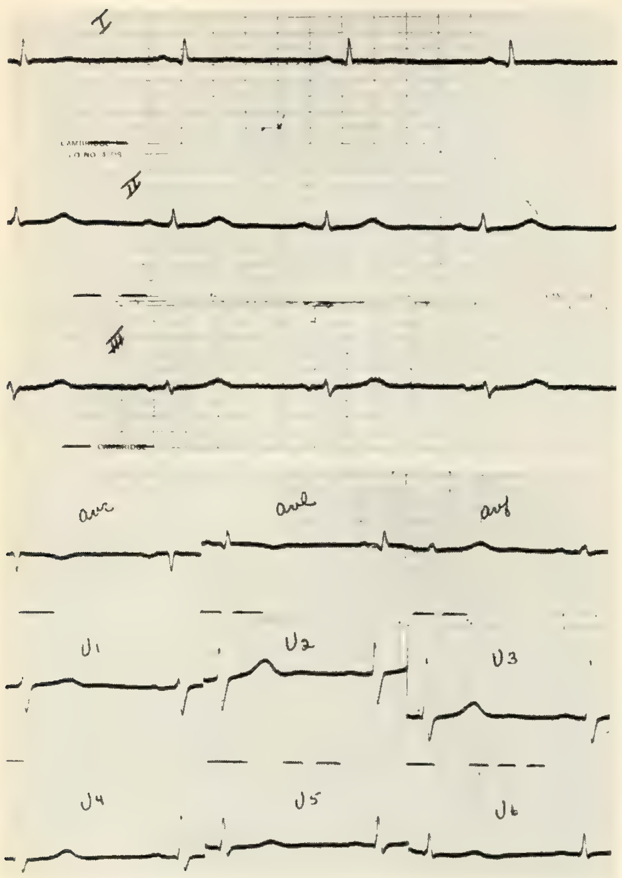

FIG. 3. Electrocardiogram, 48 hours after admission of Case No. 2, showing the most abnormal changes during the course of illness.

TABLE III.

Enzyme Profile on Case No. 2
F. W., 64-Year-Old Male, Admitted 3/21

	3/21	3/22	3/23	3/24	3/25	3/26
SGOT	48	246	166	80	24	20
LDH	580	1380	1680	1200	860	820
HBD	92	225	225	215	152	110
CPK	7	15	4	2	0	0
ISO	POS	POS	POS	POS		

minimal changes. Forty-eight hours after admission he demonstrated the electrocardiographic changes shown in **Figure 3.** Note a flat T-1 and inverted T-AVL. Five days later the pattern was unchanged.

Table III summarizes his enzyme profile. The CPK and LDH isoenzymes were diagnostic some six hours after the clinical onset. Twenty-four hours after the onset all of the enzymes studied were abnormal. Each normalizing at the expected rate.

Case No. 3—N. W., a 65-year-old white male, was admitted to the hospital 12 hours after the clinical onset of substernal pain. The initial enzyme studies were done some 24 hours after admission or 36 hours after the clinical onset. **Table IV** summarizes the enzyme profile. Note, that 36 hours after clinical onset all of the enzymes under consideration except CPK are abnormal. This demonstrates the transient abnormality in the CPK. This enzyme had apparently fallen to normal by the time the initial studies were done.

Discussion

An increase in the aforementioned enzymes in serum after myocardial infarction is directly attributed to damage of heart muscle cells. The elevation of activity has correlated well with the severity of the infarct provided the sampling has been often enough to observe a true peak level of activity, and extra cardiac factors are not contributing to the serum alteration. **Figure 4** summarizes the average reaction time span in peak of serum activity of these enzymes. Following myocardial infarction activity increases in serum in the following order: (1) CPK, (2) SGOT, (3) LDH, (4) HBD. The normalizing tendency also follows this sequence. The LDH isogram parallels the rise and fall of HBD.

Both the CPK and SGOT rise early in the course of myocardial infarction and return to normal within 72 to 96 hours. The transient rise in enzyme activity has made it difficult to interpret normal CPK or SGOT levels. This is particularly true of CPK which may be followed by a rapid fall in activity after it reaches a peak. The CPK and SGOT are unreliable indices of myocardial infarction after the fourth day post-infarction. Hess[17] has suggested that CPK should have a paramount role in the laboratory diagnosis of myocardial infarction.

We disagree with this view somewhat, and feel that this enzyme should be reserved for evaluation of the patient with a sudden onset of severe angina in which the electrocardiographic changes are minimal or negative. Timing is critical in the interpretation of CPK. The exact onset of chest pain must be accurately known before a valid judgment can

TABLE IV.

Enzyme Profile on Case No. 3
N. W., 65-Year-Old Male, Admitted 12/21

	12/22	12/23	12/24	12/25	12/27	12/29
SGOT	118	66	60	95	95	24
LDH	760	800	520	420	420	420
HBD	175	125	125	125	100	92
CPK	2	0	0			
ISO	POS	POS	POS	POS	POS	POS

be made. The procedure is unreliable in patients suffering from vauge or intermittent chest pain.

LDH and HBD show a greater latitude in sampling due to their longer period of elevation. Elliott suggested that serum alpha-hydroxybuterate dehydrogenase is a useful addition to the group of myocardial enzymes because of specificity. We have not found this to be the case.[18] The serum HBD is abnormally elevated in a variety of conditions other than myocardial infarction including hematologic disorders and liver disease. The unique value of HBD is the fact that it remains elevated longer than any of the other enzymes under consideration. This is of particular value in those patients seen some days after clinical onset of their disease.

The LDH isogram is probably the single, most sensitive and specific assay to be used in the diagnosis of myocardial infarction. This procedure lends organ specificity as well as showing a relatively early rise and a prolonged elevation. Lactic acid dehydrogenase is found in high levels in liver cells as well as myocardium. The isogram is of particular value in differentiating elevation in serum LDH of myocardial origin from LDH of hepatic origin. Patients with myocardial infarction may develop cardiac decompensation during the course of their disease.

With heart failure enough central lobular liver cell necrobiosis can occur to give an abnormal elevation in serum LDH. Using only the total LDH the clinician is left with the dilemma as to whether the rising LDH represents an extension of the original infarct or represents liver cell necrosis from hepatic vascular congestion.

The isogram clearly defines this situation. We have had cases of arteriosclerotic heart disease and EKG evidence of complete left bundle branch block who have suddenly developed acute congestive heart failure with elevation in serum LDH. It was impossible from a simple total LDH value to differentiate between congestive heart failure and heart failure precipitated by a silent coronary. The former showed an increase in the slow-moving fractions only while the latter showed an increase in the fast-moving fraction. The isogram again defined this situation clearly. With the development of a simple method of fractionation this procedure is not only highly desirable but feasible for ordinary clinical use.[19]

Conclusions

1. LDH isoenzyme fractionation is the most discriminative and sensitive test for diagnosis or confirmation of a diagnosis of myocardial infarction.

2. The HBD because of its early rise and long duration of activity as well as relative specificity is the single enzyme of choice in the diagnosis of myocardial infarction.

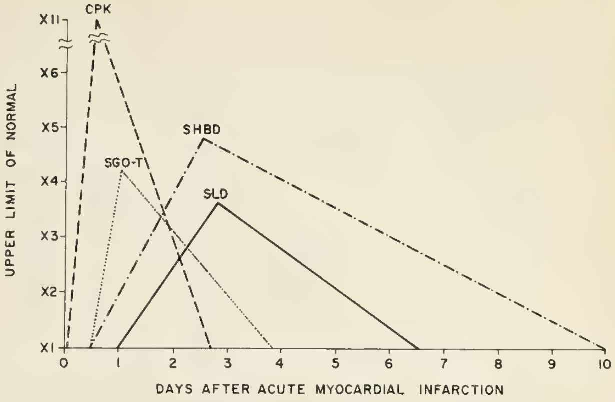

FIG. 4. A summary of the time activity curves of the four enzymes under consideration.

3. SGOT is of least value in this group because of its relative non-specificity and transient rise and rapid fall.

4. CPK although organ specific should be reserved for those cases in which exact timing of clinical onset can be made. It is most valuable in differentiating angina from true myocardial infarction.

5. Colorimetric methods are adequate and acceptable for clinical use.

* * *

Acknowledgments—The authors wish to acknowledge and technical assistance of Bonnie Stuart, and Rachael McClumpha.

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(Continued on Page 761)

The Resilient Radial Nerve

By JOHN O. GOODSELL, A.B., M.D., F.A.C.S.
Saginaw

The discovery of wrist-drop in a fractured arm can be disconcerting. This is particularly true if the discovery is made after treatment has been initiated. All traumatized upper extermities should be evaluated throughly before treatment is started, and the evaluation should obviously include assessment of nerve function.

The surgeon's sense of self reproach is assuaged if, upon the diagnosis of nerve palsy after treatment of the fracture, his record reveals the palsy to have been present pre-treatment. Uneasiness overtakes him, however, who observes a nerve deficit after treatment and finds the record to have shown either no nerve problem or no reference to nerve function beforehand.

The former instance is less disconcerting than the latter because there is at least a clue to the cause when thorough diagnosis precedes treatment, and appropriate treatment depends upon accurate diagnosis.

Fracture of the humerus may injure the radial nerve because that nerve hugs the humerus in much of its course through the arm. Contusion of the nerve (the esoteric *axonotmesis* of English literature)[1] may be produced by bone ends in closed fractures or in compound fractures not penetrated from without inward.

* * *

THE FOLLOWING cases illustrate that the author learned by experience, facts which others have written; note that each of these is a supracondylar fracture in a child:

Case #1

R. K., a 10-year-old boy, was admitted to Saginaw General Hospital 10-16-56 with a supracondylar fracture of the right humerus. Within an hour a Kirschner wire was passed through the olecranon under general anethesia, manipulative reduction done, and the arm suspended in overhead traction (known locally as "Blake suspension"). The following day a radial nerve palsy was observed which was not present before manipulation. On 10-20-56 the radial nerve was explored anterior to the elbow, and found stretched across the end of the proximal fragment, purple and contused, not divided. Open reduction of the fracture was done and fixation by crossed Kirschner wires. The fracture healed without deformity.

On 1-21-57 no recovery of nerve function appeared. On 2-11-57 wrist extensors were functioning. On 7-10-63 recovery was complete (**Figure 1**).

Case #2

T.S., a 6-year-old boy, was admitted to Saginaw General Hospital 9-13-58 with simple fractures of the left radius and ulna, a compound, supracondylar fracture of the left humerus. All nerve function appeared to be intact. Immediate debridement, open reduction, and internal fixation with crossed Kirschner wires of the humeral fracture was done. The radial nerve was found tightly stretched across the proximal fragment. Closed reduction of the forearm fractures was done, and external splinting with double sugar tong plaster over the forearm and arm.

On 9-27-58 incomplete radial nerve palsy with dorsiflexion weakness of the wrist was recognized. A month later nerve function appeared normal. On 7-15-63 nerve function was normal and there was no deformity except a slight decrease in elbow carrying angle.

Case #3

T.D., a 3-and-one-half-year-old boy, was admitted to St. Mary's Hospital 9-26-62 with a supracondylar fracture of the left humerus. The same day a Kirschner wire was passed through the olecranon under general anesthesia. Complete manipulative reduction was not done. Overhead traction was established. About four days later dorsiflexion weakness of the wrist was identified with certainty. (This illuminates the obvious fact that evaluation of nerve function is difficult in inverse ratio to the child's age because of communication problems.)

On 11-2-62 wrist drop remained in evidence. On 11-23-62 incomplete nerve recovery had occurred.

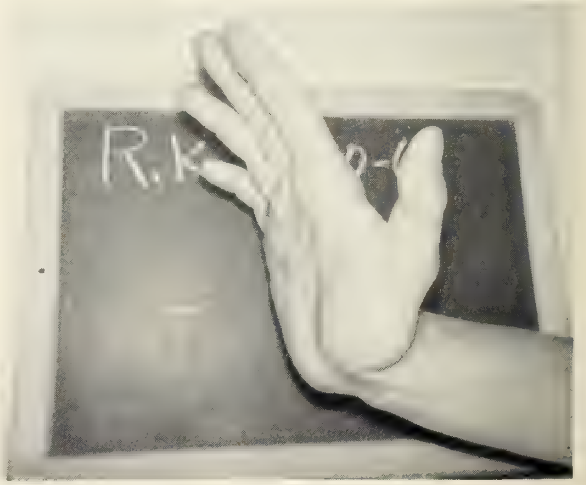


Figure 1.

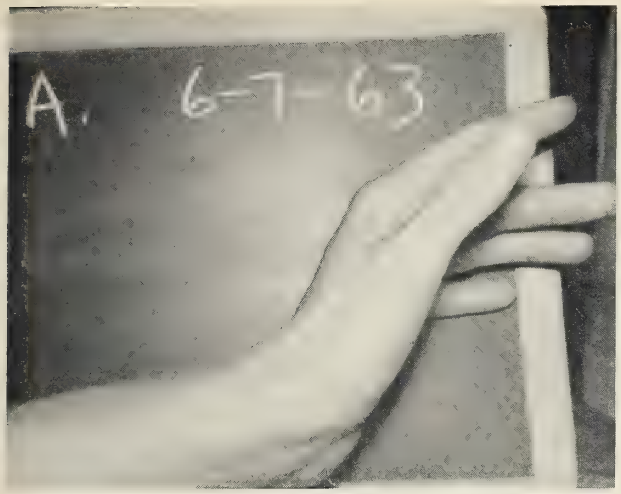


Figure 2.

On 7-10-63 nerve function was normal, and this elbow hyperextended about ten degrees compared to the right.

* * *

CONTUSION MAY be associated with an open wound such as open reduction. Division of the nerve may also. The next two cases illustrate some possibilities.

Case #4

H. F., a 27-year-old man, was admitted to Saginaw General on 9-2-56 with fractures of the shafts of the left femur and left humerus. Two days later simultaneous open reduction with intramedullary fixation of both were done, the humeral fracture by the author. At operation the radial nerve was identified and retracted. Postoperatively complete radial nerve palsy was discovered. Because no nerve function had recovered after three months, neurolysis was done 12-17-56. The nerve was intact, tightly bound in scar and callus. Slight function of wrist extension could be demonstrated 2-20-57. On 5-17-57 normal motor function had returned.

Case #5

R. A., an 11-year-old boy, was brought to the author's office 10-31-59 with a history that he had caught his left arm in a farm machine in June 1958 and sustained simple fractures of the radius, ulna, and humerus. The latter had been operated upon and fixed with plate and screws. He had been unable to dorsiflex his wrist and digits since. X-ray examination showed a humerus of normal configuration apposed by a metal plate and four screws. A linear scar was present on the mid-lateral arm. At operation on 11-25-59 separate ends of the radial nerve were readily found to terminate on either side of the metal plate and its contact with the humerus. The plate was removed. Neurorrhaphy was done.

Active dorsiflexion of the wrist first appeared about 5-10-60. By 11-18-60 all motor function was normal except for slight weakness of the abductor pollicis longus. On 6-7-63 motor function was normal. (Figure 2. Purists will observe finger extension is incomplete. The boy had, in fact, normal extension comparable to the opposite hand.)

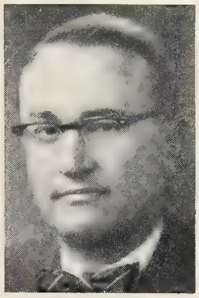
* * *

INSPIRED BY THE success of the foregoing case, the author decided to attempt neurorrhaphy in the next, clearly less auspicious, situation. Youth was on the side of R. A.; though not ancient, D. S. (Case #6) at age 21 possessed not the vigorous regenerative potential of an 11-year-old boy.[1] The delay between wound and repair was almost the same: 18 months for R. A., 19 months for D. S.[1,3] The extent of trauma and tissue loss were considerably greater for D. S.[1]

Case #6

D. S., a 21-year-old man, was seen first on 5-17-63 with a history that his left arm had been perforated by a close range shot gun blast (20 gauge) in November, 1961. Fracture of the humerus resulted, and he was told also division of a nerve. Traction was used; the fracture failed to heal. Tibial bone graft was done in March, 1962. No effort was made to repair the nerve. Examination on 5-17-63 revealed an ununited fracture of the midshaft of the humerus with a moderately invaginated scar adherent to the humerus. There was a total, paralytic wrist drop. A tiny metal plate with loose screws was visible in the area of the pseudarthrosis by x-ray.

At operation 5-31-63 the fracture was fixed with an intramedullary bone graft fashioned from a section of the left fibula. A prolonged search of the scar was rewarded by discovery of the divided ends of the radial nerve. The osteosynthesis had naturally produced some shortening of the humerus, so that reasonably healthy appearing nerve ends could be approximated. A shoulder spica was worn three months. Thereafter a sling was worn with a cock-up splint to the wrist. It was finally deemed safe so far as fracture healing was concerned to permit unrestricted activity on 2-1-64; light activity was begun three months previously.



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After one year no nerve recovery was apparent. On 6-1-64 arthrodesis of the wrist with several tendon transpositions was done; these produced reasonably satisfactory hand function by 12-4-64, at which time there was still no evidence of radial nerve function.

* * *

THE CAUSE OF radial nerve palsy may be obscure. So-called "drunkard's palsy" probably results from prolonged pressure on the nerve when the victim lies stuporously with his arm on an unyielding object, such as a saloon table top. Alcoholism will confuse the picture with the questions of avitaminotic neuritis. It may be impossible to elicit an obvious cause, as in Case #8.

Case #7

O. O., a known alcoholic, age 60 years, was seen 10-12-61 with numbness and weakness of the left hand and wrist. This was said to have developed suddenly and spontaneously the day before. Examination demonstrated a nearly complete, below elbow radial nerve palsy with trace wrist extensors. One week later partial recovery had occurred. Vitamin B_1 was prescribed, but it is not known whether it was taken. About six months later recovery was reported to have transpired.

Case #8

D. K., a 14-year-old girl, was seen 11-23-63 with a complete below elbow radial nerve palsy on the left which developed gradually over the previous ten days. Actually it probably developed in a 24- to 48-hour period, and she may simply have awakened one morning with it. She was fitted with a cock-up splint. On 5-18-64 there was no demonstrable radial nerve motor function below the elbow. Electromyography at University Hospital, Ann Arbor, on 6-23-64 was reported to show normal triceps, some recent re-inervation of extensor carpi radialis and extensor digitorum communis. On 5-8-65 she demonstrated clinically normal radial nerve function.

DISCUSSION

Empirical observation has delineated several factors of consequence to recovery of function after peripheral nerve injury. Basically three types of trauma may occur: closed stretch or contusion injury, cleanly incised wound, or contaminated wound. The first will usually recover spontaneously and need be explored only after sufficient time has elapsed to make spontaneous recovery doubtful.[2] Here the rule-of-thumb of 1 mm. per day[2] or one inch per month[3] recovery rate from site of wound distally can be used to determine the necessity for exploration. The second should be sutured primarily or in about six weeks, and this depends on many factors which include point of view,[1,4,5] technical competence of the surgeon[1] and others. In the third instance debridement should be done, the nerve ends tagged, followed by secondary neurorrhaphy in about six weeks.[1,5]

The duration of repair delay after injury is significant. The maximum period of delay compatible with reasonable recovery is said to be 20 months.[3] Seddon refined this further to the specific nerve injured and to the level of injury.[1] Seddon also commented on the length of nerve substance lost and its influence.[1] In the case of the radial nerve the maximum loss of length which may be overcome is 8 cm.

The particular nerve involved, and the level of the injury influence the chances of recovery.[1,3] Neurorrhaphy of a "simple nerve" such as radial or sciatic (simple because they contain mostly motor fibers) requires less accurate cross-section apposition for functional recovery than does a more mixed motor-sensory nerve such as the median.[3]

* * *

FINALLY THE age of the patient is important. The exuberant reparative potential exhibited by children to practically any trauma in comparison to adults holds in nerve regeneration also.[1]

The eight cases described illustrate most, but not all of these principles.

CONCLUSIONS

1. The radial nerve is resilient and will recover its function in most cases if provided proper opportunity.
2. In closed injury proper opportunity means patience and faith (plus proper splinting and perhaps electrical stimulation for muscle protection), followed by operative exploration when sufficient passage of time warrants it.
3. In open injury proper opportunity means adequate wound douche and neurorrhaphy, either at once or at six weeks. Rarely is longer delay justifiable.
4. Optimism must be properly balanced against pessimism. Too much of the former will prolong "observation" beyond the time when anything will help. Too much of the latter will paralyze treatment efforts which may well succeed.

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Genesis and Sequelae of an Automobile Accident —Medical Aspects

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There are many factors in the production of motor vehicle accidents. These include the physical and mental problems of the driver, the requirements for licensing, and the responsibility of the physician.

Human failure accounts for more accidents than any other single cause.

Therefore the physician must realize the importance of his role in the prevention of these accidents. He is the only person able to determine the physical, mental and emotional health of his patient and he can thus evaluate any existing disability that could affect safe driving.

* * *

THE PHYSICIAN should assume the responsibility for certifying fitness for driving and it is his moral obligation to use every effort at his command to persuade a patient to refrain from driving when the patient cannot drive with safety. The patient will frequently resist such advice because of the inconvenience. Persuasion to discontinue driving may require time and effort and the careful evaluation of all the facts. Nevertheless it must be emphasized that the safety of the driver and of the public is paramount.

There are several publications that will assist and guide the physician in evaluating his patient.[1] Some factors to be taken under consideration in the evaluation of the driver are whether or not he drives on a lightly traveled country road or in heavy city traffic, whether or not the patient drives for a short or long period of time, if he earns a living driving, has responsibility for passengers, or is required to drive in all types of weather conditions.

The value of the physician's role in the reduction of motor vehicle accidents has been shown in the results of a comprehensive medical program in a large urban transportation company,[2] This program consisted of careful preplacement and periodic examination of all bus drivers. An accident reduction of 50 per cent was effected as a result of this program. The details of the history and physical examination have been presented elsewhere.[1b] but briefly it should be a complete physical examination including a urine analysis, a complete blood count, chest x-ray and electrocardiogram.

* * *

IT HAS BEEN recommended that civilian drivers be examined every three years up to the age of 45 and every two years thereafter and that commercial vehicle and transportation drivers have a preplacement and periodic physical examination every two years up to the age of 45 and annually thereafter.[1b]

Medical examinations as part of a licensing program for motor vehicle operators will present many difficult problems because a large number of persons will be required to be examined. Such examinations will have to be performed over a long period of time. The administration of such a program will also offer many obstacles. However, the Commonwealth of Pennsylvania has shown that a program can be undertaken without too much difficulty. Kentucky is also in the process of developing a similar program.

Medical Problems in Driving

Since adequate research has not been completed showing the direct relationship between any medical condition and an accident, the physician must utilize his knowledge and common sense in an effort to develop criteria. The criteria for driver limitation should be based on these conditions which might suddenly incapacitate a driver through unconsciousness or the physical inability to drive with safety.

The most frequent conditions causing driver limitation are as follows: 1. Severe, uncorrectable visual disturbances, or reduction in visual fields or peripheral vision; 2. chronic alcoholism and the drinking driver who is not necessarily a chronic alcoholic; 3. mental illness, severe neuroses or psychoses or mental retardation including immature personality; 4. the use of drugs, including drug addiction or insulin, which might make a driver unsafe to drive; 5. cardiovascular diseases that could lead to sudden unconsciousness or disability; 6. neurological defects or neuromuscular illnesses or

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convulsive disorders; and 7. severe physical deformities that could interfere with safe driving.

We must realize that every candidate must be individually evaluated, that some forms of illness may cause short-term disabilities while others are chronically disabling. The Committee on the Medical Aspects of Automotive Safety of the American Medical Association published a special report in the Journal of the American Medical Association on February 1, 1964, concerning these disabilities.[3]

Physical Disabilities

Vision. Adequate vision is essential for safe driving. In addition, visual fields and eye muscle balance should be within normal limits. The patient's ability to see in the dark must also be evaluated. Color blindness per se does not seem to be an important cause of accidents. It is usually accepted that persons with less than 20/40 vision should be referred to an ophthalmologist in an attempt to improve vision. Anyone with less than 20/70 corrected vision in the better eye should be advised not to drive. The visual fields should be 140 degrees or better for driving with safety. A visual field of less than 110 degrees causes tunnel vision, and persons with this condition should not be allowed to drive. Muscle imbalance may produce diplopia, and every effort should be made to correct this abnormality.

It has been shown that accidents may occur in a driver with normal vision who is inattentive and does not perceive what his eyes are able to see.

Alcohol. Alcohol is a well-known cause of a large number of motor vehicle accidents that are attributed to speed, reckless driving, driving on the wrong side of the road, and many other infractions of the law. The best rule is to prevent anyone who drinks from driving. It has been shown that the levels of alcohol in the blood sufficient to interfere with driving performance are much lower than was realized. Studies show that .05 per cent, or 50 mg of alcohol per 100 cc of blood, cause significant deterioration in driving skill. It has been estimated that one drink may be tolerated; that two drinks impair a driver for approximately two hours and that three drinks are too many.

Psychologic Disturbances. Low intelligence, youthfulness, aggressiveness, and social irresponsibility are the usual characteristics associated with persons who have repeated car accidents. Emotional disturbances are also an important cause of motor vehicle accidents, since they may temporarily incapacitate normal people. The driver may also become temporarily antagonistic, impulsive or aggressive. He may be thinking about the argument he had before he left home that morning or the difficulty he had with his office supervisor. He may become depressed or angry and say, "I don't care what happens now." He may be worried about some personal or financial problems.

All these factors might easily cause a normal person to become involved in an automobile accident. For this reason, people who are easily upset should be advised against driving during the period of their emotional instability.

Persons with psychoneuroses must be evaluated by their physician to determine whether or not they can drive with safety. The psychotic patient must also be evaluated individually. Most psychotic patients are likely to be in hospitals and therefore unable to drive. Those who have been released from a hospital must be observed very carefully before being permitted to drive.

* * *

The older driver presents special problems. He may not be able to perceive danger or interpret warning signals rapidly because of his failing sensory abilities. He may be unable to move in a rapid or co-ordinated manner.

Youthful drivers may use a car to express their egos. Improper attitudes such as these are often causes of reckless driving, resulting in accidents.

Metabolic Diseases. The most important metabolic disease for consideration in driving is diabetes mellitus. The patient with diabetes, controlled by diet alone or by diet and oral drugs, can safely drive any type of motor vehicle. If he requires insulin, and the diabetes is well controlled, he may be permitted to drive a private motor vehicle. However, the brittle, or uncontrolled, diabetic patient may have sudden attacks of hypoglycemia. Therefore he should be advised against driving under any circumstances.

Drugs

Patients may take drugs on their own or those prescribed by a physician and may not realize the serious effect the drugs may have on their ability to drive safely. Many of the cold tablets sold by pharmacists contain antihistamines that may cause drowsiness and therefore endanger safe driving. The physician must remember to advise his patient to determine the effects of any new medication before he attempts to drive, since some patients are very sensitive to drugs.

Central Nervous System Depressants

Hypnotics, sedatives and anesthetics produce depression and drowsiness. Small doses may temporarily improve a nervous person's ability to drive but may cause sleepiness. The tranquilizing drugs such as meprobamate, chlorpromazine hydrochloride, reserpine or other hypertensive drugs may also produce drowsiness in some patients.

Great care should be taken when the drug is first given to be sure that drowsiness does not occur.

Central Nervous System Stimulants

Central nervous system stimulants such as amphetamine cause temporary alertness and efficiency, but the patient must be cautioned that this is only a transitory effect and that he should not expect the medication to keep him awake for prolonged periods. It should also be stressed that large doses of such stimulants may cause dizziness, agitation, irritability, and a decreased ability to concentrate.

Antihistamines. Antihistamines and drugs preventing motion sickness usually cause dizziness and drowsiness. Any patient taking such medication should be cautioned not to drive until he knows that the medication will not cause sleepiness or interfere with his safe driving.

Cardiovascular Diseases. Patients with the following conditions should not be allowed to drive because of sudden unconsciousness: aortic stenosis, severe disturbances in cardiac rhythm, and severe hypertension.

Hypertension per se is not disabling, but its complications—damage to the brain, eyes, heart, or kidney—may very well prove so. Complications involving the optic fundus with a degree of impairment in vision may be extremely serious.

Arteriosclerotic heart disease is a serious problem that requires individual evaluation. Some patients with mild coronary disease may very well return to normal and drive under certain circumstances. However, a patient who has had a serious coronary occlusion with extensive myocardial infarction should not be permitted to drive under conditions of stress and strain. Certainly if he is a professional driver, he should be most carefully evaluated before he is permitted to drive.

Neurologic Diseases. Convulsive disorders, irrespective of their etiology are a most important and serious problem to be considered in motor vehicle accident prevention. The epileptic patient should not be permitted to drive unless he is seizure-free for a minimum of two years and he is under medication and constant medical supervision. He might be permitted to drive, if he submits to regular examinations every few months. Such a patient, of course, should not drive professionally.

Neurologic disorders affecting muscular control and coordination such as paralysis agitans, poliomyelitis, multiple sclerosis and mental deterioration require individual evaluation on the part of the physician. Usually, patients with these disorders are not fit to drive.

Physical Deformities. Uncompensated arthritis, skeletal and amputation deformities may make it impossible for a candidate to physically control the levers of an automobile and to drive with safety. Many attachments have been developed to assist these disabled persons to drive with safety.

* * *

MOTOR VEHICLE accidents represent one of the most serious Public Health problems confronting the medical profession today. Most doctors have not accepted this as their problem, as they would poliomyelitis, pulmonary tuberculosis, cancer or heart disease.

The physician must realize the importance of this problem, and accept his responsibility and his vital role in the prevention of motor vehicle accidents.

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Evaluation of Serum Enzyme Tests

(Continued from Page 755)

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Chemotherapy With Delinquents

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ABSTRACT—This manuscript describes some of the advantages of treating severely disturbed delinquents under court jurisdiction with an initial institutionalization in court facilities and a prolonged probationary period with frequent return to the out-patient clinic of the child and his parents. Chemotherapy and brief psychotherapy was begun in the institution and continued on probation until the child improved.

Delinquency, one of our most serious social problems, remains an engima with little prospect of being solved.

Children, whose delinquent outbursts lead them to the attention of the Juvenile Court, become even more of a challenge to authority if the underlying cause of their misbehavior is related to psychosis, brain damage, mental deficiency, or serious emotional disturbance. These delinquents with mental problems should be cared for in state mental institutions.

Mainly because of the overcrowded situation so commonly found with the state facilities, the local communities have experienced considerable difficulty and delay in admitting these children into state facilities. This delay in placement has forced many counties and local communities either to develop their own special facilities, or to seek new methods in treatment and care of these problem children.

* * *

FOR YEARS, the Juvenile Court of Oakland County, Michigan, experienced such difficulty. Delay in some cases was a year or longer. Meanwhile, these children had to receive care in the county facilities housed with the delinquents. Such arrangement was unsatisfactory because, in the first place, it seemed unfair to the children to delay treatment until beds were available in a state institution.

Secondly, they needed special housing, care, and attention for which the building constructed for detention of delinquents was inadequate, and the staff trained to work with delinquents found it practically impossible to be of help to those sick children.

In May, 1960, Juvenile Court Judge Arthur E. Moore decided that psychiatric treatment utilizing drug therapy when suitable, should be tried because of favorable results reported in recent literature, such as the following studies.

* * *

Burks[2] discusses the use of tranquilizing drugs with children and emphasizes their efficacy in helping the anxious child to interrupt the vicious cycle which is often set up, a cycle in which a sensitive child is adjusting negatively, gets severely reproved, does less well and then makes an even worse adjustment. He differentiates sharply in how efficacious are drugs for various types of malfunctioning children, finding the most dramatic response to be that of the psychotic child, that the response of the brain-damaged child was good and that the least responsive was the aggressive child with a negative parental background. A particular effort was made by Burks to discriminate between those whose aggressive actions and frequently anti-social behavior have an organic basis and those with whom there is an environmental basis.

This is not easy, and indeed Bender,[1] with her long experience in treating brain-damaged children, felt that the greater part of those who come to official attention have problems, both organic and emotional. A child who has considerable difficulty in learning or in developing controls, invites antagonism and rejection from all sides.

For the proper use of medication, a more precise diagnosis is desirable than simply one of severe emotional disturbance. An example of the types of disturbance commonly found among children and adolescents is given by Masterson, et al.[6] They found, in a succession of 101 adolescent patients, five chief syndromes: thinking disorders (which included the openly psychotic and those whose disturbance was suggestive of pre-psychotic states), psychoneurotic disorders with several sub-groups, acting out disorders, depression and hysteria. Of these, 40 per cent had a history of psychiatric symptoms beginning in childhood, with the thinking disorders and the acting out disorders inclined to appear earliest.

Schwade and Geiger[7] discuss a similar group showing severe behavior problems. They found in a study group of over 1000 patients that certain electroencephalogram findings related to impulsive destructive behavior with the precipitating incident rather small. This type of disorder was found more often in males, started comparatively young, and persisted even when intelligence was normal or above. Adjustment and achievement were inadequate in almost every field; these children constituted a threat to their family and society in some cases. Organic injury ranging from prenatal damage, to encephalitis or accidental injury was suspected as a cause.

Treatment consisted of medication with a number of different drugs alone or in combination, depending on the response of the individual child, and psychotherapy was seen as an indispensable adjunct. They believed that the disorder is a result of thalamic, hypothalamic (or amygdalic) and/or limbic disease or trauma and say, "This is not to be misconstrued as a type of epilepsy except that it resembles a seizure, which by definition is a "sudden attack."

* * *

IN THE YOUNGER group of children seen for drug therapy, a common problem is extreme hyperactivity. Kirman[4] in describing the use of tranquilizers for children with this symptom advocated a careful trial in modifying the environment first before using medication, particularly in the case of children who have special unmet needs, such as the need of a deaf child for communication. He found that trifluoperazine (Stelazine) and thioridazine (Mellaril) were the most useful drugs in modifying extremely inappropriate and restless behavior. Once a satisfactory adjustment is made, he advocates gradual reduction with use of placebos if needed, and remarks that at best drugs are an adjunct to the use of environmental and personal relationship therapies.

In treating 400 children, ages from two to 17, many from broken homes and institutions and with varying symptoms, Freed[3] found a number of paradoxical situations, not unlike those found in the present experience to be described.

One of particular interest, affecting treatment sometimes to a marked degree, is the resistance of the child to taking a tranquilizer for fear of being labelled "crazy" by peers and the resistance of the parents on other grounds—even when medication makes a marked improvement in the child's general adjustment.

Doctor Freed felt that the beneficial effects of the medication far outweighed the dangers resulting from side effects. He found Stelazine particularly useful with psychotic children and meprobamate useful in minor difficulties, but he used a number of other preparations while trying to work out the most suitable medication for each case. As in the experience of others, medication is seen by him as most effective when combined with other forms of treatment.

A double blind study made by LaVeck and Buckley[5] on a group of retarded children with behavior disorders used a number of different tranquilizers in succession. In discussing results, they said that the phenothiazine derivatives appear to be most effective, particularly in severely to moderately retarded individuals who are difficult to manage because of hyperactive and destructive behavior and conclude that "One must be prepared to encounter many failures, yet the excellent results that are occasionally seen warrant a trial of therapy."

As the retarded children who are held in the Juvenile Court facilities while waiting placement in state institutions are very likely to be those with severe behavior problems, the above is particularly applicable.

The use of drug therapy was initiated in the Oakland County Juvenile Court Clinic on an informal basis when one of the consulting psychiatrists was asked to treat a few of the more disturbed children in one of the court facilities. The partially favorable result of this treatment led to increased referral, sometimes of children unsuitable for this type of therapy. Systematic selection procedures were set up by which children were referred for thorough psychological examinations by the staff psychologists of the court. In addition, social studies of the children and psychiatric examinations were made.

* * *

THE COMBINED IMPRESSION of this team—psychologist, social worker and psychiatrist—determined if the referred child was suited for drug therapy. Eventually, this service was extended to include children who had come to the court but were living home under court supervision. The cooperative effort of the team with the institution staff and court workers was of great importance in carrying out treatment plans. In addition, some of the children on medication were given psychotherapy by the psychologists or the social workers.

In 1960 an extensive drug therapy program was not contemplated. However, 70 children are now being treated. This includes children and adolescents in the court facilities and in their own home, the last including those whose treatment was begun while in court facilities and those who have been able to remain home from the beginning. About 125 children have been seen regularly for brief psychotherapy and/or adjustment of their medica-

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Wholesale prices for patented prescription drugs have decreased considerably more than the prices for non-patented drugs: The wholesale list prices for patented prescription drugs have declined an average of 23.9 per cent since 1949 while prices for non-patented prescription drugs have decreased 1.9 per cent.

tion since the program started.

Within the group of children and adolescents treated at the Oakland County Juvenile Court Clinic there were a larger proportion of "acting out" disorders than would probably be found at a non-court-connected clinic; however, most of the diagnostic categories were seen. Among those whose behavior brought them to the attention of the court fairly young were a number of brain-damaged children diagnosed by psychological testing and electroencephalograms. Of those children whose problems at home or in the community were serious enough for comparatively lengthy stays in county facilities, approximately one out of seven boys were referred for drug therapy and one out of four girls.

The main categories of children and adolescents treated were those with thinking disorders (schizophrenic or pre-schizophrenic; in general, those whose thinking processes deviated markedly from reality), the brain-damaged, the epileptic, the severely depressed and the neurotics with severe anxiety.

The treatment of choice of the last two categories is psychotherapy, but medication was frequently helpful. Character disorders as a group did not respond and were screened out as far as possible.

In making the above diagnoses, which is perhaps more difficult in children than in adults, social history, psychological testing, electroencephalograms and neurological examinations were accomplished. In addition, response to medication and extensive observation of behavior were also used as aids to diagnosis.

* * *

THE DRUGS WHICH have been found most effective with adolescents with thinking disorders were those in the phenothiazine group. Stelazine has been used frequently as it was found to be very effective. Taractan has also proved useful. With very disturbed children, Thorazine has been used. Mellaril has appeared to be the drug of choice with those children having symptoms of both brain-damage or epilepsy and schizophrenia. With the younger children with schizophrenic-like disorder, Mellaril has been found helpful.

The drugs which have been used most with the hyperactive brain-damaged child are Dexedrine, Ritalin, Librium, Mellaril and, infrequently, Benadryl. One or two children, when they were first seen, were receiving Geminol. Some brain-damaged children respond to the phenothiazines. The barbiturates rarely seem to help the brain-damaged child and may exacerbate the symptoms.

Epileptics, as expected, responded to the anticonvulsants. A considerable amount of trial and error was found necessary in some cases to find the correct drug combination. Only the Grand Mal form of epilepsy is consistently diagnosed before the child comes to court. Unless there was a severe emotional problem the treatment of an unsuspected form of epilepsy improved the child's behavior and ability to function.

At times children with borderline abnormal E.E.G.s with markedly aggressive behavior but no definite epileptic symptoms, respond to dilantin when no other drug seems to help.

Neurotic children respond to the barbiturates and benadryl and the mild tranquilizer provided there is considerable anxiety or depression. Many neurotics respond to placebos as effectively as to drugs. Conversion symptoms rarely respond to medication.

A few of the depressed schizophrenics and neurotics are benefited by the anti-depressant medication. The endogenous forms of depression are rarely seen in children.

* * *

WITHIN THE GROUP treated were children ranging in age from four to 17; most of the younger children were diagnosed as suffering from brain damage or retardation with emotional disturbance. Those loosely classified as schizophrenic and apparently suffering from some type of thinking disorder averaged around 15 or 16. The younger children and a few of the adolescents were neglect cases rather than delinquents and were frequently long-term responsibilities of the court. Within both these legal categories, the family members exhibited a considerable degree of pathology, including a number who were, or had been, psychotic.

TERMINATED CASES

Diagnosis	Male	Female	Total	Number improved	Average duration of treatment
Schizophrenic	13	7	20	14	10 Months
Brain damage with emotional disturbance	8	1	9	6	9 Months
Brain damage with schizophrenia	5	0	5	2	12 Months
Epileptic with emotional problems	2	1	3	2	8 Months
Neurotic	9	1	10	7	3 Months

ACTIVE CASES

Diagnosis	Male	Female	Total	Number improved	Average duration of treatment
Schizophrenic	16	8	24	19	9 Months
Brain damage with emotional disturbance	17	3	20	15	9 Months
Brain damage with schizophrenia	2	0	2	2	11 Months
Epileptic with schizophrenia	1	0	1	1	10 Months
Neurotic	3	6	9	7	4 Months
Retarded with emotional problems	3	2	5	4	11 Months

Notes explanatory of table: terminated cases do not necessarily represent cases no longer in need of treatment, many being terminated because the age of the adolescent removed the case from court supervision. Those classified as improved range from children able to make a satisfactory community and home adjustment to those whose condition necessitates continuing institutionalization, but in a way more satisfactory to themselves and others.

In examining this table, which attempts to summarize roughly the results, it should be remembered that this was a service program and not intended as a scientific study to compare methods of treatment or to study the effect of different drugs.

Each child was placed on the drug or drugs which produced the optimum result and in a number of cases this involved much trial and error. As the child improved, medication was reduced or stopped. Some cases seen briefly are not included in the table since after study they were not considered suitable for this type of therapy.

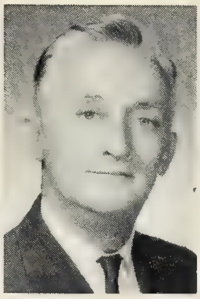
Since some of the children reported every two to four weeks for as long as two years at the clinic, there was much more use of psychotherapy than had been anticipated. The children were brought to the clinic, as a rule, by the parents or foster-parents after return to the community was made; the ensuing contact with the parents helped to give them insight into which of the child's symptoms the medicine controlled and to give them some appreciation of its worth. This learning process for the parents of children on probation is a very important advantage of this program.

* * *

IN AN EARLIER experience in drug therapy with children, where participation was entirely voluntary, it was found that parents were inclined to drop the use of the medication because of emotional reactions to the use of "dope" or because of the initial drowsiness of the child before the dosage was adjusted. With adequate court supervision this is less likely to happen; it is here that the insistent role of the court is particularly important. The court, through court workers assigned to each child, reports and acts on the child's behavorial symptoms, thus supplementing and strengthening the parents' care. Parents' worries in regard to addiction and to effects of the medication on growth were expressed but they were counseled to understand medically that their worry about the addiction effect is not well founded. Unless there is fairly close and prolonged supervision of a child after returning home, the parents gain little insight; this is a serious problem nullifying the effects of a good therapeutic program in some institutions.

* * *

ONE OF THE main advantages of providing this service through the court is that the child remains near his local community. He may go home weekly if his condition permits and this allows his re-adjustment to home and community more rapidly. At first, it was disappointing to find children were placed home, then returned to stay in the institution because of failure to continue medication on their own. Later, it was realized that both parents and child learned the effectiveness of the drugs upon observation of resulting behavior problems due to failure to maintain medication. It seems that early release and frequent return if necessary may be better for the child than longer institutionalization and little supervision upon return to the home.



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Besides the above-mentioned possible benefits of this system, there are specific advantages. The use of medication reduced the length of institutionalization. As a rule, medication should be started in the detention home and the final behavorial changes and effects of medication observed while the child is in the institution. If the results are favorable, the child may be released to his own home on probation to report to the clinic regularly. As an example of the results sometimes achieved, it was possible to release one bright schizophrenic adolescent who responded rapidly to medication after only one month, and a second was home in two months. Other children could have been released sooner were it not that this would cause an interruption in schooling started while in the center.

The drugs in almost all cases improved the child's school work. The brain-damaged child became less hyperactive and had an increased attention span. Frequently, behavior improved to an extent that the school in their community would accept them, though they had previously been dismissed for unacceptable behavior.

The schizophrenic child also benefited in his ability to learn and control his behavior. To a lesser extent, this was true of the neurotic and epileptic children.

Since the program started, no child with the diagnosis of epilepsy or brain damage has been committed to a state institution, although two children with the combined diagnosis of brain damage and schizophrenia showed little improvement and were committed. Five schizophrenic children (the term "children" includes those of adolescent age also) who showed little or no improvement were also committed. Three children with very destructive behavior were committed. Three children who were being held while awaiting admission to schools for the retarded and who had been unable to stay home because of severe behavioral problems, showed sufficient improvement to be returned to their homes.

* * *

THE COST OF this service is not large in proportion to its advantages for the child and the public. The part-time services of a psychiatrist, a social worker and psychologists are needed to process about 70 children who are on the current case load.

Summary

This paper has described some of the advantages of treating delinquent or neglected children who have severe disturbances without removing them from the local community. The particular advantages of having treatment begin and terminate under the auspices of the juvenile court are described, particularly that a return to the clinic is made mandatory.

It is felt that the use of medicine shortened the length of institutional stay, facilitated learning and enabled the child to receive psychotherapy more readily. The return visits to the clinic were believed to enhance the parents' understanding of their child's problem and assisted them in their efforts to help the child. Re-admission of the child to the center when necessary, was seen as an advantage rather than a disadvantage.

This system for treating children in the categories discussed allows for long probation under supervision, which is far less costly than long institutionalization and permits the child to reside in his home and community.

It is hoped that some of the ideas in this paper could be used in other communities with similar problems.

* * *

Acknowledgments—The authors wish to express their appreciation to Honorable Arthur E. Moore, Honorable Donald E. Adams, Honorable Norman R. Barnard, Barbara J. Bebout, M.A., and Andrew T. Yang, Ph.D., for their help in reading the manuscript. They also wish to express appreciation to Miss Virginia Brandon for the preparation and typing of this manuscript. Without their assistance this article could not have been made possible.

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Coming in November

Watch for an excellent presentation on a new technique for lung scanning with radioisotopes as a diagnostic aid in pulmonary embolism, carcinoma of the lung and other pulmonary problems. This fine article from Ann Arbor will be accompanied by a well-illustrated article on Masked Mastoiditis, a report on the complete rupture of the term gravid uterus with delay before hysterectomy, information on X-Ray Pelvimetry and Cephalopelvic Disproportion and an unusually fine series of five cases of Pathologic Rupture of the Spleen.

Three of the cases reported occurred in patients with Hodgkin's Disease, a rarely reported fatal phenomenon.

These and other articles by Michigan authors will merit your attention.

OFFER GUIDE ON DRUGS

More than 17,000 copies of "New Drugs: 1965" have been sold to physicians and other medical personnel by the American Medical Association.

The AMA-published book, designed to give the medical practitioner useful, concise, timely authoritative and continuously updated information on new single-entity drugs, is now in its second printing.

Orders for the book may be placed with the American Medical Association, 535 N. Dearborn, Chicago, 60610. The AMA sells the volume at cost: $5 per copy, or $4 if the purchaser is a house officer or medical student.

Observations on Salmonellosis in Michigan

G. H. Agate, M.D., M.P.H.
D. B. Coohon, D.V.M., M.P.H.
Both of Lansing

There are now over 900 Salmonella serotypes, and new serotypes are being found almost daily. All of these serotypes are considered to be potentially pathogenic for man and animals.

Some serotypes are apparently host specific or at least have marked host preferences, such as S. *typhi*, the causative agent of typhoid fever. These serotypes are apparently the exception to the rule which is that salmonellae colonize all species of animals with apparent equal facility.

* * *

WE WILL confine this paper to the non-host adapted serotypes which constitute one of the greatest problems in clinical medicine today. These salmonellae produce a wide spectrum of illness, ranging from asymptomatic colonization of the intestine of the host to an acute enteritis which may terminate in bacteremia and death. Fortunately, the latter is rare, usually occurring in persons with preexisting debilitating conditions. Although persons of all ages are affected, the most severe clinical syndromes are seen in the very young and the markedly debilitated.

When hospital outbreaks occur, they are nearly always seen in the newborn nurseries, pediatric wards, and in surgical wards—particularly in gastrointestinal surgery.

Foodborne infections in large groups of persons are the most dramatic and well publicized. More persons are at risk and are involved, however, in what we call family outbreaks.

Epidemic Patterns

An S. *newport* family outbreak started with the father (Case 1), a farm machinery repairman. His illness (fluid stools for two days) was probably due to contact with infected manure on a piece of farm machinery.

(Case 2) Gary, Jr., age two, had a touch of vanity. He was continually combing his hair with water, which is not too bad, except that he used the water in the toilet bowl. Gary became ill one week after his father.

(Case 3) The mother became acutely ill one week after Gary. During this time, she was trying to keep Gary in dry diapers which she said was an endless task.

(Case 4) Ronald, four months, became ill two or three days after the mother's diarrhea began. Both the mother and Ronald were hospitalized.

(Case 5) Ricky, four years, became a transient and asymptomatic carrier. The sixth member of the family, Debra, age three, did not pick up S. *newport* during the time the family was being sampled.

If good isolation techniques had not been employed in the hospital, where cases 3 and 4 were sent, a situation such as the following could have occurred.

S. *oranienburg* was the serotype involved in at least four cases of Salmonellosis in a community. The index case was in a breast-fed infant whose mother was told raw eggs were good for babies. This child developed a severe diarrhea and was hospitalized. In an adjoining bed in the pediatric ward was a three-month-old male child recovering from a severe respiratory illness. This child was discharged with loose stools. Subsequently, two siblings of this child became infected and ill with S. *oranienburg* diarrhea. An attempt at isolation of S. *oranienburg* from the poultry flock involved was not successful although all evidence incriminated it. S. *oranienburg* has been isolated from raw, frozen and dried eggs in the past. Fresh grade A shell eggs are very infrequently found to contain salmonellae. Cracked and checked eggs are very frequently found infected.

Our smaller hospitals in Michigan, receiving patients from predominantly rural areas, are especially at risk from salmonella cross-infection. This is illustrated by the following episode.

During January and February the community and hospital was experiencing an outbreak of apparent viral gastro-enteritis. Stool specimens taken in pediatric wards were repeatedly negative for Salmonella, Shigella, and pathogenic *E. coli*. On the last

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day of February, the first isolation of S. *typhimurium* was made from the stools of a one-month-old child who was admitted four days previously. In the next month (March), ten children from one month to nine years of age were found to be infected with S. *typhimurium* while in the overcrowded ward.

* * *

ABOUT THE middle of March it became apparent to the hospital staff and to our surveillance that hospital-acquired infections were occurring. Our laboratory was alerted to save cultures submitted for serotyping, put them through sensitivity tests and submit them to the Communicable Disease Center Laboratory, Atlanta, Georgia, for phage typing. A visit was made to the hospital in response to the administrator's request for assistance. It was apparent that improvement was needed in techniques, particularly handwashing by personnel and general care of equipment and housekeeping. Immediate steps were taken by the medical staff and administrator to correct these deficiencies.

A close scrutiny of the hospital records of the cases revealed some interesting data. Two of the cases admitted with diarrheal illness due to S. *typhimurium* were children with rural addresses and were receiving home pasteurized milk products. One of these two cases was the sibling of the apparent index case in the outbreak. This added to our confidence that we had found case 1 and that the rural community was the reservoir of infection which was spilling over into the hospital community.

Further evidence supporting this thesis came our way after the institutionally acquired problems were solved. Two children were admitted under isolation techniques and immediate stool samples were obtained. Both proved to be S. *typhimurium*, phage type la variant, and of the same antibiotic sensitivity pattern as the strain found in the previous hospital-community problem. One of these infants came from a dairy farm known to be experiencing extensive losses of new-born calves with diarrheal illness due to S. *typhimurium*, phage type la variant, antibiotic sensivity pattern identical to the child's strain.

Information and follow-up cultures on the dairy cattle, grandparents and parents of the child revealed that the disease had existed in the dairy herd for three months before the onset of the child's illness, and that both the mother and father had loose stools during this time. The grandparents, who also lived on the farm, were found to be asymptomatic (or temporary) carriers.

Two cases of S. *saint paul* have recently been reported by a local health department. Circumstances were very similar in that illness was in breast-fed infants and both homes contained new puppies (not "house broken") with diarrhea. In one case, the puppy was found infected with S. *saint paul.* The other puppy was disposed of before fecal samples could be obtained from it. Young mothers caring for sick or well puppies and for new babies is certainly inadvisable. Some dog foods, particularly fresh or frozen raw meats, have been found to contain salmonella organisms.

* * *

IT HAS BEEN adequately demonstrated by many investigators that many items in our food supplies contain salmonellae. The human food and animal feed industries are cognizant of this situation and steps are being taken to correct the problem as quickly as possible. However, until human foods and animal feeds are finally freed of salmonella organisms, it would seem advisable to be sure all segments of our society are informed of this potential hazard.

Role of Therapy in Outbreaks

One cannot help but be impressed with the apparent prophylactic role played by the so-called normal intestinal bacterial flora. Experimental evidence in animals supports the observation that normal bacterial inhabitants of the gut are vigorous competitors with salmonellae. Institutionally acquired outbreaks are usually sharpest where the majority of patients have an "underdeveloped" intestinal flora due to: oral antibiotics; gastrectomy or other previous extensive gastro-intestinal surgery; just haven't picked up a "normal" flora (newborn).

In the above-described hospital outbreak, all the cases acquired in hospital were receiving oral antibiotics for pre-existing conditions such as otitis media, infected toe, upper respiratory illness, pneumonitis. At the other end of the spectrum, all of the nursing staff on duty at the time of the outbreak were "free" of salmonella on repeated laboratory culture of feces. That they did not pick up the organism attests well to their own personal hygiene, the "normality" of their intestinal flora and the sensitivity (?) of present laboratory methods.

The point is, oral antibiotics tend to render the host more susceptible to salmonellae in that it takes a much smaller dose (number) of organisms to establish an acute infection. This gives the clinician an insight into the therapeutic rationale of some of his problem cases.

We have frequently been asked, "How can I rid my patient from salmonella infection? She has had loose stools and has been shedding the organisms for a month, and I have tried every antibiotic available." Very frequently one can have best results by using antibiotics only during the acute phase of the illness. Then withdraw the antibiotic and let the "normal" flora become re-established.

The vast majority of patients respond well to this procedure. Good personal hygiene and a reasonably clean environment are also important to discourage massive re-infection of the patient.

Doctor Payne Chosen 101st President

Hiscock, Hayes, And Lightbody All Returned

C. Allen Payne, M.D., Grand Rapids, will serve as the 101st MSMS President in 1966-67.

Doctor Payne was chosen by the MSMS House of Delegates September 21 when James J. Lightbody, M.D., Detroit, was re-elected as Speaker of the House.

Harold H. Hiscock, M.D., Flint, was re-elected as Chairman of The Council at the organizational meeting of The Council, September 23.

The House of Delegates re-elected Louis F. Hays, M.D., of Gaylord, as Vice-Speaker.

The House also re-elected the following Councilors: Ralph R. Cooper, M.D., Detroit; John J. Coury, M.D., Port Huron; A. Carl Stander, M.D., Saginaw; Edward H. Rodda, M.D., Bay City; and Robert J. Mason, M.D., Birmingham. Beginning three-year terms on The Council will be Milton R. Weed, M.D., Detroit; Eugene R. Elzinga, M.D., of Marquette; and John R. Pedden, M.D., of Grand Rapids.

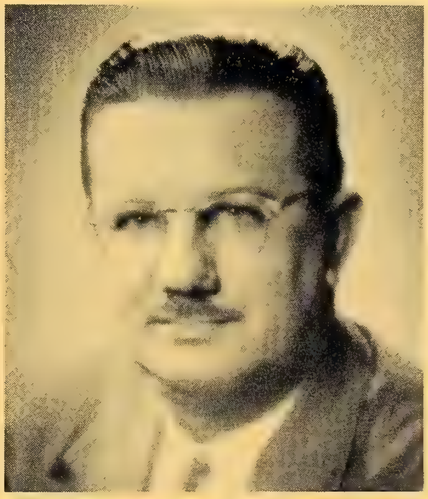
The following were chosen as Delegates to the AMA: J. R. Heidenreich, M.D., Daggett; Luther R. Leader, M.D., Birmingham; William A. Hyland, M.D., Grand Rapids; and Robert E. Rice, M.D., Greenville.

Selected as Alternate Delegates were: Wyman C. C. Cole, Sr., M.D., Detroit; B. M. Harris, M.D., of Ypsilanti; Otto K. Engelke, M.D., Ann Arbor, and G. B. Saltonstall, M.D., Charlevoix. Joseph A. Witter, M.D., Detroit, was elected as an Alternate Delegates to fill an unexpired term.

At the organizational meeting of The Council Robert J. Mason, M.D., Birmingham, was continued as the Vice-Chairman.

Renamed as Chairman o fStanding Committees were Ross V. Taylor, M.D., Jackson, County Societies; and B. M. Harris, M.D., Ypsilanti, Publication. Robert K. Whiteley, M.D., Grosse Pointe, was named as Chairman of the Finance Committee, a position formerly held by Doctor Payne.

Doctor Payne has been a member of The Council for sometime and served as General Chairman of Arrangements for the Centennial Session. A strong leader in medical organizational work, Doctor Payne is a member of the State Board of Registration in Medicine.



C. Allen Payne, M.D.

Historic Marker Tells MSMS Role

Following is the wording for the Michigan Historical Commission Registered Site No. 270—the marker erected at 5 p.m., Sunday, September 19, in a small Detroit city park on the west side of Woodward between Congress and Larned. The marker commemorates the site of the Michigan State Medical Society organizational meeting 100 years ago in the Michigan State Supreme Court in the Odd Fellows Hall, which subsequently was torn down.

MICHIGAN STATE
MEDICAL SOCIETY

Formation of the Michigan State Medical Society took place here, June 5, 1866, in the Supreme Court Room of Odd Fellows Hall. About 100 physicians from all sections of Michigan were present. The society adopted the code of ethics of the American Medical Association. The state society, a voluntary, professional organization, provides postgraduate training for physicians and strives to improve the public health by its public service and educational activities.

Centennial, Biggest of Michigan Events!

MSMS officials knew the Centennial Session plans were solid, but they worried about the audience.

But, the members did respond!

The Centennial attendance of 2,702 physicians, 2,000 guests and 1,062 exhibitors shot far past all previous annual session figures.

And the 5,764 physicians and guests were generous in their praise. The scientific activities were excellent, the special historic events were impressive, and the fellowship was warm and sincere.

Centennial Session planners were generous in their praise of the participants. The physicians were keenly interested in the extensive programming and challenged many of the 223 speakers who shared their medical knowledge.

News media focused on the work of the House of Delegates, the awards which paid tribute to physicians and laymen, and the medical authorities who came from the USA, Canada and England.

MSMS appreciates the efforts made by many national, world and state organizations to send representatives and telegrams.

Troost of Holt Is "Outstanding Doctor of '65"

Franklin L. Troost, M.D., of Holt, is "Michigan's Outstanding Physician for 1965."

Doctor Troost, who has an excellent record as a physician and community worker, was given this honor by the House of Delegates in Detroit. The House Committee to select Michigan's Outstanding Physician had studied the nominations from several county societies and recommended Doctor Troost as the first recipient of this new award.

The citation given to Doctor Troost read:

"In recognition of your distinguished career in medicine and community service. As a physician, you have served on the State Board of Registration in Medicine, as the Holt School Team Physician for 34 years, as a delegate of the MSMS House of Delegates, and as an advisory board member of the local polio foundation. As a concerned citizen, you have served as a member of the Dehli Township Board, as chairman of the Delhi Township Zoning Board, and as a delegate to the county and state conventions of your political party."

The 1964 House of Delegates took action "to establish annual recognition of Michigan's Outstanding Physician." The resolution, which was approved, outlined his award "as an annual recognition of a member of the profession, who is not necessarily a family physician, nor one advanced in years," In many ways, his award replaces the discontinued "Foremost Family Physician Award."

ST. IGNACE — Herbert E. Hamel, M.D., recently was honored as the Man-of-the-Month by the Kiwanis Club. Doctor Hamel, active in many community affairs, began his practice at St. Ignace in 1947.

Time to Enroll In WSU Classes

Physicians interested in continuing medical education courses offered by Wayne State University School of Medicine may get full details from the office of the registrar at 1400 Chrysler Freeway.

Many of the fall quarter courses began in September, and still others are scheduled for this month and at future dates.

Following is a list of some of the specific short-term courses still to begin:

Regional Anatomy, Head and Neck, October 6-December 15

Regional Anatomy, Thorax, Abdomen and Pelvis, October 7-December 16

Regional Anatomy: Back and Limbs, October 1-December 10

Anesthesiology Seminar October 6-December 6

Seminar in Physiological Chemistry, September 27-December 6

Biological Catalysts, September 27-December 6

Electrocardiography, October 13-December 8

Basic Course in Psychiatry, November 16-April 5

Postgraduate Seminar in Pediatric Psychiatry, November 18-April 7

More Centennial News in November

The deadline for this hot-news section fell on September 20—however some of the hot, news-breaking events of the Centennial Session have been included. This was possible only through the excellent cooperation of our printer.

Details about the House of Delegates and the other activities — along with photo coverage—will appear in the November issue of MICHIGAN MEDICINE.

MSMS To Conduct Clinical Programs in Three Cities

Fall PG Activities Offered In 23 Michigan Communities

Nineteen postgraduate lectures and hospital clinical programs will be offered across the state this fall by the MSMS Postgraduate Medical Education Committee.

All physicians are urged to attend the one in their area, or one nearby. Promotional folders with details about times, places, speakers and subjects have been mailed to all MSMS members, except those in the Detroit-Ann Arbor area. (No programming is offered in the metropolitan area because the committee and Council believe those doctors have ample opportunity for PG courses at the two medical schools.)

Afternoon hospital clinic programs were popular last spring and are being offered this year at Marquette, October 21; Midland, November 18, and Grand Rapids, December 9.

In addition to Marquette, Midland and Grand Rapids, Lower Peninsula locations for the evening programs, are listed below in chronological order.

OCTOBER 5—BATTLE CREEK
OCTOBER 5—LANSING
OCTOBER 15—MUSKEGON
OCTOBER 19—NILES
OCTOBER—20—GRAYLING
NOVEMBER 4—ALPENA
NOVEMBER 7—PORT HURON
NOVEMBER 9—TRAVERSE CITY
NOVEMBER 11—PETOSKEY
NOVEMBER 16—JACKSON
NOVEMBER 18—MIDLAND
DECEMBER 9—GRAND RAPIDS

Following is the Upper Peninsula Schedule:

OCTOBER 18—HOUGHTON
OCTOBER 18—SAULT STE. MARIE
OCTOBER 19—ESCANABA
OCTOBER 19—IRONWOOD
OCTOBER 19—MANISTIQUE
OCTOBER 20—IRON MOUNTAIN
OCTOBER 20—MENOMINEE
OCTOBER 21—MARQUETTE

Time to Plan For Community Health Week

Observances of the 1965 Community Health Week, November 7-13, conducted under the leadership of local medical societies, will afford all local health groups and agencies a splendid opportunity to demonstrate how they're "Teaming Up for Better Health" of the community.

The primary purpose of the observance is to direct public attention at the local level to the health progress and medical advances which have been made and to the abundance and quality of health services and facilities.

The AMA is distributing a kit of promotional materials and program suggestions as the starting point for planning.

The 1964 programs generally followed one of four principal themes—promotion of health services and facilities; campaigns against health hazards; promotion of emergency preparedness; and community health education.

The statewide efforts in Michigan once again are being coordinated by the Michigan State Medical Society, Michigan Health Council and the Michigan Association of the Professions.

Towsley to Preside At AAP Conclave

EVANSTON, ILL.—More than 3,000 pediatricians are expected to attend the 34th annual meeting of the American Academy of Pediatrics to be held October 23-28, 1965, at the Palmer House in Chicago.

Panels and symposiums will cover carbohydrate metabolism, interpreting teenagers to parents, recent epidemics, newer antimicrobial agents, and other subjects.

Current president of the Academy is Harry A. Towsley, M.D., professor of pediatrics and communicable disease at the University of Michigan Medical School, Ann Arbor.

House Commendations Given Hodges, Leucutia, Robinson

Three distinguished Michigan physicians were presented Certificates of Commendation by the 1965 House of Delegates.

They were: Fred J. Hodges, M.D., Ann Arbor; Traian Leucutia, M.D., Detroit; and Remus G. Robinson, M.D., Detroit.

Doctors Leucutia and Robinson were present September 21 to receive the certificates from MSMS officials. Doctor Hodges was out of the state and will receive his award at the next Washtenaw County Medical Society meeting.

The three were recommended by the special House of Delegates Committee on Certificates of Commendation from 16 nominations. The 16 names had been suggested by component societies or committee members.

The citations read as follows:

"To Fred J. Hodges, M.D.—In recognition of his distinguished career in radiology and in training doctors, especially during his 34 years with the University of Michigan; and also for his outstanding contributions to the Atomic Energy Commission, Michigan Pheonix Project and American Cancer Society."

"To Traian Leucutia, M.D.—In recognition of his distinguished career as a radiologist at Harper Hospital; as a past-president of the Michigan and national roentgen ray societies; as editor of his specialty journal; and for his extensive research and paper on radiation therapy."

"To Remus G. Robinson, M.D.—In recognition of his fine service as a practicing physician and surgeon in Detroit for 25 years and as a distinguished public servant. He has served his community well as a member and president of the Detroit Board of Education, and as a leader in many other civic efforts."

Jaycees Study Mental Health

More than 100 Jaycee leaders from the nation conferred September 13-15, at the University of Michigan Medical Center, to find ways for improving the nation's mental health and to discuss special projects.

The Jaycees made mental illness and retardation an area of their special concern several years ago.

The U-M meeting was planned by Raymond W. Waggoner, M.D., chairman, U-M department of psychiatry and member of the advisory council of the Michigan Jaycees' Mental Health and Mental Retardation Committee, with Stuart M. Finch, M.D., professor of psychiatry and chief of children's psychiatric services at U-M, and Jaycee officers.

A telegram message of congratulations and best wishes was extended by MSMS President Oliver B. McGillicuddy, M.D.

In Brief:

MUSKEGON — The September meeting of the Muskegon County Medical Society featured a medicine and religion program with the clergymen as their guests. Charles A. Hubbard, of the AMA Department of Medicine and Religion, spoke.

* * *

PHILADELPHIA — The 200th anniversary of medical education in the United States will be observed here as the American Medical Association holds its 19th Clinical Convention November 28-December 1.

The convention will help mark the bi-centennial observance of the University of Pennsylvania School of Medicine. Physicians and their families will be able to participate in ceremonies observing the school's founding.

* * *

SAN FRANCISCO — George E. Cartmill, director of the Harper Hospital, Detroit, was chosen by the American Hospital Association convention here as the association's president-elect. He will be installed next year at the annual meeting in Chicago.

Brief Explanation of Social Security Provisions as They Apply to Physicians

I am a self-employed doctor; when must I report?

Your earnings from self-employment in the practice of medicine for taxable years ending on or after December 31, 1965, will count toward social security benefits for you and your family. (Most physicians must report their self-employment earnings for social security purposes in 1966 when they file their 1965 income tax returns.)

How can I become insured for the benefits?

You need credit for a certain amount of work under social security for benefits to be payable on your account. The work credits under social security are measured in calendar quarters, with four quarters of credit being equal to one year of work.

If you are a self-employed physician, you get four quarters of credit for each year in which your net earnings from self-employment are $400 or more.

If you are an employee, you get one quarter of credit for each calendar quarter in which you are paid wages of $50 or more.

To be insured for disability benefits—you need credit for at least five years of work in the 10-year period ending when you become disabled.*

To be insured for retirement and survivors' benefits—in general, the amount of work you need depends on the year you reach age 65 (62 for women) or on the year of your death if you die before that age. The following table shows how much work most people will need to be insured for retirement and survivors' benefits.

No one needs credit for more than 10 years of work to be insured for retirement or survivors' benefits. Survivors' benefits may be payable to your children and their mother if you have social security credit for 1½ years' work out of the three years before your death.

If you reach age 65 (62 for women) or die in—	*You will not need credit for more than this much work—*
1957 or earlier	1½ years
1958	1¾
1959	2
1960	2¼
1961	2½
1962	2¾
1963	3
1964	3¼
1965	3½
1966	3¾
1967	4
1968	4¼
1969	4½
1970	4¾
1971	5
1975	6
1979	7
1983	8
1987	9
1991 (or later)	10

Can I get credit for payments I made once before?

About half of America's self-employed physicians have, at some time, done work that was covered by the social security law. Thus, you may already have social security credit for some work. Also, if you were in the military service of the United States between September 15, 1940, and December 31, 1956, you may get social security credit for your active duty (unless it is counted toward certain other Federal benefits). Military service after 1956 is covered by the law in the same way as other kinds of employment.

How are the benefits determined?

Being insured means only that you are eligible for benefits. It does not determine the amount of the monthly benefits payable to you or your family. The benefit amount depends on your average earnings under social security.

To determine the amount payable your earnings are averaged over a period of years starting with 1951 and continuing to the year you reach retirement age (65 for men and 62 for women). What this means (unless you were born in 1930 or later) is that you must consider the years 1951 through 1964 in figuring your average earnings, even if you do not have social security credit for any earnings in those years. However, five years in which you had low earnings or no earnings under the system may be dropped in figuring the average.

What are the benefits that Social Security pays?

For you—old-age insurance benefits and disability insurance benefits;

For your family—wife's benefits, mother's benefits, child's benefits, childhood disability benefits;

In the event of your death—widow's benefits, mother's benefits, child's benefits, childhood disability benefits, dependent parent's benefits, lump-sum death payment.

The brochure by the Federal government and available from MSMS lists details of the above benefits.

Will I have to retire completely to get benefits?

You don't have to retire completely to get benefits. But if you expect to work while getting benefits, it is important to know how your earnings may affect your social security payments. While under age 72, your total earnings and the number of months you work are the two things which determine how much in benefits can be paid to you.

Social Security Folder Available

In response to a number of requests to MSMS, the following basic information is offered to MSMS members explaining new elements of the Social Security Law.

This copy is excerpted from a new U.S. Department of Health, Education and Welfare brochure about the Law and how it relates to physicians.

Interested physicians may obtain a complete copy of the brochure by writing to MSMS for "Social Security for Physicians' Brochure."

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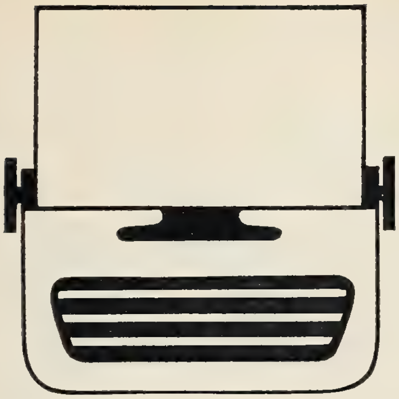
*Under the new law, if you become blind before age 31, you need credit for only one year of work for every two years after age 21 and before you become blind.



EDITORIAL VIEWS

DIOGENES SAID . . .

"The foundation of every State is the education of its youth."

So spoke Diogenes and his words are even truer today than when he said them.

The Michigan Council of State College Presidents and the Michigan Coordinating Council for Public Higher Education report that there are nearly a quarter of a million students currently enrolled in Michigan colleges, both public and private, and that this figure will almost double in the next decade. The 10 four-year public colleges and universities alone in the fall of 1964 had a 14,000 increase in on-campus enrollment.

* * *

THE ENROLLMENT explosion is accompanied by a knowledge explosion and every year, and even every day, there is more to learn. Competent faculty members, increased financial support, more classrooms, laboratories, and libraries —all are needed.

Year-around operation is spreading in Michigan's publicly supported institutions of higher learning.

* * *

THE LEGISLATURE in 1964 recognized the need for improvement in appropriations for higher education, yet still more is needed. Governor Romney, in advocating fiscal reform, anticipated a need for $200,000,000 of increased state revenue in two years and much of this will be needed for higher education.

Diogenes said it and we must support it, "The foundation of every State is the education of its youth."

WE DISAGREE

From time to time it is suggested that pharmaceutical houses should regard their advertising in our journals as a contribution that we as physicians richly deserve because we write prescriptions for their products. Some have suggested that doctors limit pharmaceutical representative visits to those whose firms advertise in a Society publication. *We disagree!*

We desire good advertising and solicit it. However, our position is that we wish to receive advertising as a quality publication and as a worthwhile investment by the advertiser. We do not seek alms and to do so is, in our opinion, beneath the dignity of any reputable medical publication. The advertiser is entitled to his money's worth and we try to give it to him.

PTA ADOPTS RESOLUTIONS FOR HEALTH ACTIVITIES

Physicians and their wives have many opportunities to provide professional guidance to the 400,000 PTA members in Michigan as local PTA units work within the framework of resolutions adopted at the Michigan Congress of Parents and Teachers 1965 Convention.

Many of the resolutions dealt with various aspects of health. The MCPT Board of Managers now will depend upon its Health Chairman to implement the action programs, and local PTA Health Committees will seek to work at the grassroots.

The Michigan PTA Convention adopted a resolution in favor of a proposed continuous health supervision program. MSMS has been represented on the planning committee for such a project. The resolution declared, "As a desirable

LOMOTIL *Pharmacologic Activity*

The significant pharmacologic actions of Lomotil are summarized as follows:

Evidence indicates that Lomotil acts directly by inhibiting excess peristalsis.

Lomotil is not known to inhibit nonpropulsive intestinal movements.

Roentgenograms demonstrate that this activity occurs within two hours after oral administration and persists for at least six hours.

Comparative studies in the rat show Lomotil to be more effective in inhibiting fecal excretion than either codeine or morphine.

Analgesic, anticholinergic, mydriatic and gastric secretory effects have not been significant.

Reduction of propulsive motility with Lomotil relieves spasm and cramping, allows physiologic absorption of fluid and reduces frequency of evacuations to provide prompt, symptomatic control of virtually all diarrheas.

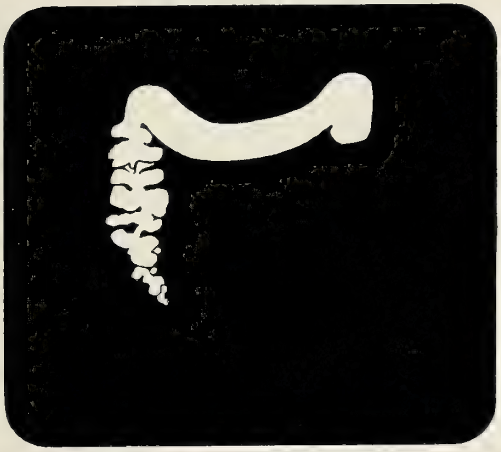
LOMOTIL®

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride (Warning: May be habit forming)	2.5 mg.
atropine sulfate	0.025 mg.

tablets • liquid

slows propulsion



relieves distress

stops diarrhea

Precautions: Lomotil is an exempt narcotic preparation of very low addictive potential: more than three million prescriptions have now been written for Lomotil. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, *given in divided doses,* until diarrhea is controlled, are:

Children:
3 to 6 months—3 mg. (½ tsp.* t.i.d.)
6 to 12 months—4 mg. (½ tsp. q.i.d.)
1 to 2 years—5 mg. (½ tsp. 5 times daily)
2 to 5 years—6 mg. (1 tsp. t.i.d.)
5 to 8 years—8 mg. (1 tsp. q.i.d.)
8 to 12 years—10 mg. (1 tsp. 5 times daily)

Adults:
20 mg. (2 tsp. 5 times daily or
2 tablets 4 times daily)

**Based on 4 cc. per teaspoonful.*

Maintenance dosage may be as low as one fourth the therapeutic dose.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE *Research in the Service of Medicine* extension of the summer roundup program, the Michigan Congress of Parents and Teachers strongly urges its councils and local units to develop means for the implementation of the Continuous Health Supervision Program of the National PTA." (MSMS members will be interested in knowing that Mrs. Elizabeth Margulis, of the AMA staff, is vice-president of the National PTA.)

One of the resolutions dealing with juvenile welfare, urged PTA members to actively work toward a better America by intensifying their efforts to combat such hazards as teenage drinking, increase of venereal disease, smoking, and traffic in narcotics.

The MCPT convention delegates took action "to object to the suggestive, lewd, violent and demoralizing material and profanity used in certain advertising and other mass media programs."

In a positive stand for quality educational programs, the PTA convention said, "Our educational expectations for our youth shall include health education, highlighting physical fitness, mental health, family life, sex education, and quackery about health and health-related products."

Physicians also will be interested in some of the legislative changes suggested by the PTA in the field of traffic safety. A PTA resolution called for more adequate laws dealing with the state licensing, safety inspection and supervision of all amusement rides.

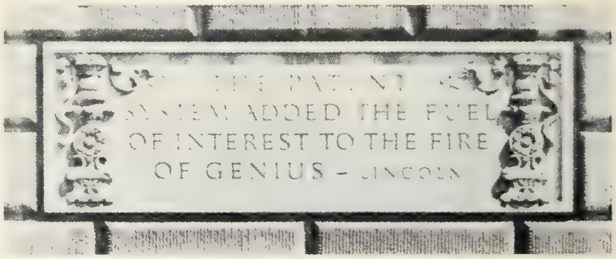
Because litter can lead to health problems, the medical profession will support PTA anti-litter campaigns. A resolution urged "all PTA councils and locals to promote community programs of action in order that more communities might become more aware of this ever increasing blight."

ON LOOKING AHEAD

"Medicine has an ever-expanding list of responsibilities to itself, to allied professions, and to each and every community across the land. We must cooperate and be active in as many pertinent programs as possible that will promote the art and science of medicine and the betterment of the public's health.

"We must have great vision—looking ahead to see how we can do an even better job. We cannot fail to look ahead because of a fear of the future."

—Donovan F. Ward, M.D.
AMA Immediate Past President



OF BIRTHDAYS AND PATENTS

1965 is the 100th Anniversary of the Michigan State Medical Society. Perhaps not so well known is that it represents the 175th Anniversary of the first United States Patent Act (one of the nation's oldest laws).

Abraham Lincoln said "the patent system . . . added the fuel of interest to the power of genius . . ." In our field of medicine, it is important for us to recognize that drug patents encourage research and competition while making it possible for the smaller research-minded families to grow and to get ahead.

The publication of information on patents provides greater fertilization of ideas and stimulates scientific progress. Many research scientists report that their number one source of new information is patents.

Few, if any, new drugs or inventions have been commercially developed in countries which do not offer proper patent protection to the inventor. Of the new drugs introduced in the United States from 1941 to 1964, 369 came from the United States, 44 from Switzerland, 33 from Germany, and 28 from the United Kingdom. Equally significant is that 90 per cent of the 369 new drugs originating in the United States came from company laboratories. On the occasion of the Michigan Centennial, we are happy to express birthday greetings to the patent law on its Sesquicentennial.

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ideally suited for routine screening

accurate—comparable to the older standard intradermal tests
practical—can be administered by nurses under physician supervision
convenient—no refrigeration or other storage precautions
economical—stable for 2 years, self-contained disposable unit

Side effects are possible but very rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis. *Available* as the new individually-capped unit, boxes of 5, or in cartons of 25.

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11 MSMS Members Serve as Officers of AMA Sections

The newly published list of AMA Section Committees of the Council on Postgraduate Programs reveals quite a number of Michigan physicians in places of responsibility.

Alphabetically down the list of the first Michigan name is in the Allergy Section—the first section. John M. Sheldon, M.D., Ann Arbor, is the Section Delegate to the AMA.

The Dermatology roster shows Arthur E. Schiller, M.D., former chairman of the MSMS Council, as Vice-Chairman. Clarence S. Livingood, M.D., Detroit, is the Section Delegate to AMA. E. Richard Harrell, Jr., M.D., Ann Arbor, is the Assistant Secretary.

Muir Clapper, M.D., Detroit, is Chairman of the Internal Medicine Section.

Under Ophthalmology, Harold F. Falls, M.D., former Vice-Speaker of the MSMS House of Delegates, is the Section Delegate to the AMA.

The Pediatrics Section Delegate to the AMA is Edgar E. Martmer, M.D., Harper Woods, former member of the MSMS Council.

George H. Koepke, M.D., Ann Arbor, is Assistant Secretary of the Physical Medicine Section.

Serving as Chairman of the Preventive Medicine Section is Harold J. Magnuson, M.D., Ann Arbor.

Secretary of the Proctology Section is Norman D. Nigro, M.D., Detroit.

Kenneth L. Krabbenhoft, M.D., Detroit, is Assistant Secretary of the Radiology Section.

OUR STATE SOCIETY

AMA Supports MAP Concept

The American Medical Association might be characterized as being "deliberate."

It seldom accepts anybody's word for anything. Instead, when a new idea is propounded, this organization seeks the opinion of many people; watches the idea mature in the crucible of experience and then its deliberative body—The House of Delegates—debates, deliberates, and issues an opinion which, from that time henceforward, is the policy of the medical profession in these United States.

In June of this year, in New York City, the House of Delegates of the American Medical Association endorsed the formation of state associations of the professions and encouraged the development of the American Association of the Professions.

The interesting thing, of course, is that this action was taken under the same methodology as previous policies have been established. In this case the idea was born in Michigan and flowered with the incorporation of the Michigan Association of the Professions. This Association grew from a representation of five professions to a representation of the nine major ones, namely: Accounting, Architecture, Dentistry, Education, Engineering, Law, Medicine, Pharmacy, Veterinary Medicine.

A resolution was introduced into the AMA House of Delegates in June of 1962 but the House delayed approval. It wanted more evidence. Subsequently, it watched the Association grow in Michigan where it represented 93,000 people. It watched the MAP pattern emulated by other states and it liked what it saw. It noted the need for concurrent action in matters of legislation that the Association served. It recognized the potential value of this type of organization as a clearing house for understandings among the professions. It saw the potential in public relations and realized the inherent educational opportunity the Association provided.

Thus when the resolution was reintroduced in 1965, the House gave it unanimous support.

The Michigan State Medical Society has had many "firsts." Probably the action which will go down in history as one of its greatest contributions will be its part in the organizing of this inter-professional body. In turn, the support given by the AMA is an important milestone in the movement MAP represents in Michigan.

The following are the important "Resolved" portions of the adopted resolution:

"RESOLVED, That the constituent medical societies of the American Medical Association be encouraged to take a leadership role in the formation of State Associations of the Professions to provide a vehicle for interprofessional cooperation in those areas where united activity of the various professions can be of great benefit; and be it further

"RESOLVED, That the Board of Trustees of the American Medical Association be requested to consider the potential advantages of aiding in the development of the American Association of the Professions."

Lirugen(TM)

is *truly* a one shot measles vaccine.

An efficacy rate of 99% has been demonstrated with Schwarz Strain live measles vaccine (Lirugen). In recent clinical trials, Lirugen was administered without gamma globulin to approximately 13,000 children. In 1,405 of these children tested serologically, a conversion rate of 99% was reported. Close medical follow-up of inoculated children and controls showed no significant differences between mean maximum temperatures in the two groups. The incidence of high fever (103°F and above, rectally) attributable to the vaccine could be calculated at less than 1%, and the occurrence of mild, transient rash at less than 3%.

Lirugen is the most highly attenuated, but fully antigenic, live measles vaccine. Additional special passages of the original Edmonston Strain by Schwarz resulted in further attenuation which reduces systemic reactions so effectively that the use of gamma globulin with Lirugen is not needed.

Contraindications: Pregnancy; leukemia, lymphoma and other generalized malignancies; brain damage in children under one year of age; febrile illness; allergy to egg proteins, neomycin, or streptomycin. Precautions: Use cautiously in patients with a history of tuberculosis and patients being treated with steroids, irradiation, alkylating agents, and antimetabolites. Consult package literature before administering Lirugen.

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PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, U.S.A. DOW

"...it is extremely difficult and sometimes impossible to differentiate between 'pure depression' and anxiety and it is questionable whether depression without a certain degree of anxiety really exists."

Lehmann, H. E., Canad. Psychiat. Assn. J. *4(S)*: 1-12, 1959

anxiety
and
depression
depression

An antidepressant designed for the clinical realities of office practice

As many physicians have reported, the large majority of neurotic depressed patients suffer from both depression and anxiety. It may be difficult to decide whether these patients are primarily depressed or primarily anxious. And yet drug treatment of only the symptom which seems more prominent may exacerbate the untreated element of the depression complex.

Consequently, it would seem that therapy specifically aimed at both the depression and associated anxiety and tension should increase success in treatment.

This is one of the important reasons why 'Deprol' has proved particularly helpful. For 'Deprol' acts rapidly both to lift the mood and to relieve the associated anxiety, tension and insomnia.

And side effects, at recommended dosage, have been infrequent and generally readily controlled.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular. CD-5749

Deprol®

meprobamate 400 mg. +
benactyzine hydrochloride 1 mg.

WALLACE LABORATORIES / Cranbury, N.J.

LEGISLATIVE AFFAIRS

Council Appeals for More Involvement in Legislative Affairs

By Harold H. Hiscock, M.D.
Chairman, The MSMS Council

The MSMS Council has continuously examined the work of the Committee on Legal Affairs and the staff responsible for legislative contact. It has been deeply impressed with four facts:

First: The Council is of the unanimous opinion that a highly commendable job has been done and it has said so by official resolution. Faced with a nearly new State Legislature and a deluge of health-related proposals, the MSMS program was successful. A few bills which we opposed were adopted; some of the bills we proposed were not acted upon. In the main, however, those bills which were deemed to be most critical were acted upon in accordance with our desires.

Second: The legislative job will get more and more difficult. The day of relatively brief annual sessions of the State Legislature has passed. Legislators are working 365 days a year now. More and more health legislation is being proposed—and new federal programs will be reflected in even more state proposals.

Third: Our experience this spring was satisfactory due to the efforts of *many*, but that "many" was still only a few of our total membership, and a few of our members cannot do the job. The one, two or three meetings held with some senators and some representatives represent *only a start*. Our legislative contacts can no longer be casual, or part-time. Every Michigan legislator must have a regular source of medical opinion. It must be someone in his own community.

Fourth: Government relationships and governmental programs have become a part of the practice of medicine. Physicians *must* involve themselves in legislative affairs, for the laws, at a rapidly increasing rate, are affecting the practice of medicine in all of its aspects.

Wall Street Journal Sees Congress Moving More in Health Field

From Wall Street Journal

WASHINGTON—The advent of medicare, revolutionary as it seems, may turn out to be no more of a political breakthrough than a series of less publicized health measures coming out of the current Congress.

One probable effect of these bills will be to shatter a long-standing taboo against general Federal support of practicing physicians or of clinical services. Up to now, such support has been reserved for care of certain privileged classes of patients: War veterans, merchant seamen and a few people whose peculiar ailments warrant special attention by researchers.

In large part, the taboo-shattering will be accomplished through the looming establishment of a $350 million national grid of centers for diagnosing and treating heart disease, cancer and stroke; a Senate-passed bill to create this grid appears about to clear the House Commerce Committee, after winning belated support from Chairman Oren Harris of Arkansas, and seems destined to go on to approval by the full House; at Wednesday's press conference, August 25, President Johnson made a new plea for action on the bill. Under this plan, surgical teams, other hospital specialists and men who staff diagnostic stations would be paid out of Government grants, if not directly on the Federal payroll.

HEALTH GROUPS CRITICAL

Both the American Medical Association and the narrower group of practicing physicians called the American Academy of General Practice condemn this dependence on Uncle Sam as a longer stride toward socialized medicine than even their old nemesis of Government health insurance. The heart-cancer-stroke bill leaves the way open for similar combat against "other major diseases."

Actually, the line against Federal support of doc-

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tors' salaries has been pierced twice already this year by Congress, if only in a limited way. Tucked away in a cranny of the aid-to-Appalachia bill, where it attracted little notice, was $28 million for hospital staff and operating expenses in depressed communities. Appended to a 1963 construction-aid program for building community mental health centers was $221 million, spread over seven years, for their initial staffing.

What's more, another medical first may soon emerge from Congress. To expand the nation's doctor population an Administration-backed bill would make operating funds available to medical schools, and Federal scholarships available to medical students. Both provisions nettle the AMA, but the measure appears headed for final passage soon.

To further enrich the store of medical knowledge, provision has already been made for a near-doubling of funds authorized for construction of health research facilities, coupled with Congressional passing of President Johnson's billion-dollar budget for actual research work.

THE "HEALTH CONGRESS"

Taken together with medicare, these multiple thrusts add up to by far the biggest dose of health legislation ever processed through a single Congress. Assuming the heart-cancer-stroke bill gets through on schedule, "this has to be the 'health Congress' first of all," proclaims a top Democratic Congressman.

But 1965 won't be the end of such efforts. Looking to next year, President Johnson has already promised Congress a new batch of legislation aimed at three tall goals: Boosting average U. S. life expectancy to 75 years from 70 at present, reducing infant mortality by at least one-third and eliminating deaths from measles, whooping cough, diphtheria and other communicable diseases. He has indicated he may send Congress a special health message next year.

Whether the present surge of Congressional activity is itself healthy depends, of course, on who's making the prognosis. To the American Medical Association, the staunchly conservative voice of many of the nation's physicians, the growing Federal involvement plainly threatens to upset established patterns of medical practice. Even to some more liberal groups, such as the American Heart Association, the plan for heart, cancer and stroke centers smacks of heavy-handed, if well-intentioned, meddling in the allocation of medical resources.

But public health officials, medical educators and hospital administrators all see advances in both the development and dissemination of new treatment methods and in the training and placement of doctors as a result of Congress' work. With President Johnson prodding the lawmakers on against an enemy as indefensible as disease, few Congressmen have been inclined to balk.

PASSED THE SENATE

The expected approval of the heart-cancer-stroke bill by the House Commerce Committee points up

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Constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, leukopenia, muscle cramps, nausea, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
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the prevailing pressures. Though the proposal got a warm reception in the Senate and passed last month by perfunctory voice vote, it was cold-shouldered in the House until recently. Then, about the time word came out that he was in line for appointment as a Federal judge, Chairman Harris got behind the measure.

With the White House cultivating committee skeptics and Mr. Harris employing his own talent for persuasion, a "consensus" vote for the program looks probable. "The Republicans and Southern Democrats are still leery of the concept, but there's too much money in it for their hospitals and medical schools for them to turn thumbs down," says a committee Democrat. The prospective committee majority and the measure's high standing at the White House make House approval all but certain before Congress adjourns.

Under the bill, Federal health planners envision creation of 30 or more state or regional networks, each built around a medical school or teaching hospital and with spokes extending outward to community hospitals throughout the area. The objective is to bridge the gap that's said to have insulated suburban and small-town doctors from the accumulating expertise of researchers and big hospital specialists.

Money would be pumped in for strengthening the staffs and facilities of the core hospitals, especially to permit specialized heart operations and cancer treatments and to familiarize older doctors with new methods. But the funds and expertise also would circulate throughout the system, partly through establishment of diagnostic and patient routing stations in outlying hospitals. An initial $50 million is provided for the program's first year; the amount would double in the second year and double once again, to $200 million, in the third.

Because the intent is to give medical schools, hospitals and local medical societies most of the say over how the regional networks would function, the legislation itself is purposefully vague. Left unanswered are such questions as whether the local diagnostic stations would charge for their services and whether they'd be open to anyone who wants an examination or only take patients referred by participating doctors.

Congressional proponents of the measure, of course, insist there's no intent to supplant present doctor-patient relationships or patient referral practices within the medical profession. "The whole idea is to improve the services available to the general practitioner and strengthen the links between him and the specialist," says an aide to Rep. Harris.

SLAP AT DOCTORS' COMPETENCE?

But the AMA and the American Academy of General Practice remain unconvinced. Many of their member doctors take the bill as a slap at their competence, tending to undermine public confidence in the profession. In any event, the legislation would thoroughly breach the AMA's long-held line of resistance against Federal support of practicing physicians.

"It's no secret that most of your medical school people and public health men want to put the entire profession on salary and then restructure it to conform to their elaborate classroom blueprints. And this bill would give them a powerful opening wedge," contends one House Republican sympathetic to the AMA's viewpoint.

Despite its fears, however, the AMA has not stubbornly tried to block any and all Federal support of doctor's salaries. While opposed to Government staffing money for the community mental health centers, the AMA didn't make much of a fuss about it; psychiatry is a field that's long been dominated by publicly supported state mental hospitals, anyway. "Supplanting state mental hospitals with hometown treatment centers is too desirable a goal to warrant a lot of quibbling," remarks an association spokesman.

Nor does the profession have any intrinsic quarrel with the aim of another major health bill: Boosting the nation's doctor supply. Indeed, the AMA has lately joined Federal health planners in bemoaning shortages of medical personnel and the lack of medical school capacity to turn out more doctors.

When it comes to ways of accelerating medical school expansion and aiding medical students, however, Congress is going beyond organized medicine's prescription. Under an Administration-backed bill that unanimously cleared the House Commerce Committee this month and seems headed for final enactment, medical, dental and osteopathic schools would qualify for operating money in addition to the construction and equipment grants they already receive. The operating funds, totaling $200 million over four years, would go principally to poorer schools for broadening their faculties and curricula. Moreover, to promote medicine as a career, the bill offers Federal scholarships of up to $2,500 a year.

INFLUENCE OF BIG MAJORITIES

Why all the sudden legislative breakthroughs in the health field? Undoubtedly the biggest single influence is the same one that's brought smooth sailing for most Great Society proposals: The huge Democratic majorities in Congress.

A coalition of Republicans and Southern Democrats on the House Commerce Committee quietly rebuffed John F. Kennedy when he sought funds for medical scholarships and for staffing mental

NEED FREEDOM TO THINK

"Although doctors may not be free in a political sense, they must maintain intellectual freedom.

"Legislation can take away some of our freedom. But it cannot and must not be permitted to curtail our freedom to think and to feel to the best of our ability as physicians."

—James Z. Appel, M.D.
AMA President

health centers; that coalition is no longer dominant, and Republicans, in particular, have elected to get along by going along with the liberal majority. "We're too badly outnumbered to provide effective opposition, so we may as well go along and take part of the credit rather than make whipping boys of ourselves," remarks one GOP strategist on the Commerce Committee.

To some extent, penetration into the field of medical practice is considered a natural follow-up on the Government's huge investment in medical research. Since 1959, the lawmakers have nearly quadrupled annual appropriations for the Government's National Institutes of Health, regularly adding huge chunks to funds requested by the agency. Although this trend continues (the House added $12 million to this year's $1,041,000,000 NIH request and the Senate Appropriations Committee tacked on another $30 million), it's believed that much of the political mileage has gone out of championing research alone. "There's so much money on the table already that we've reached the point of diminishing returns," reasons a Senate aide.

Now the health-minded politicians are questioning whether the nation is getting a fair return on its research investment. The answer they get from most researchers is that doctors in private practice have fallen years behind in adopting new treatment methods. Hence the rationale for Federal sponsorship of the community mental health programs, the heart-cancer-stroke complexes and perhaps other things to come.

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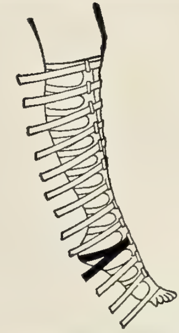

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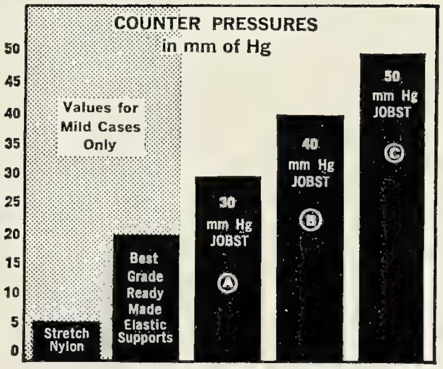

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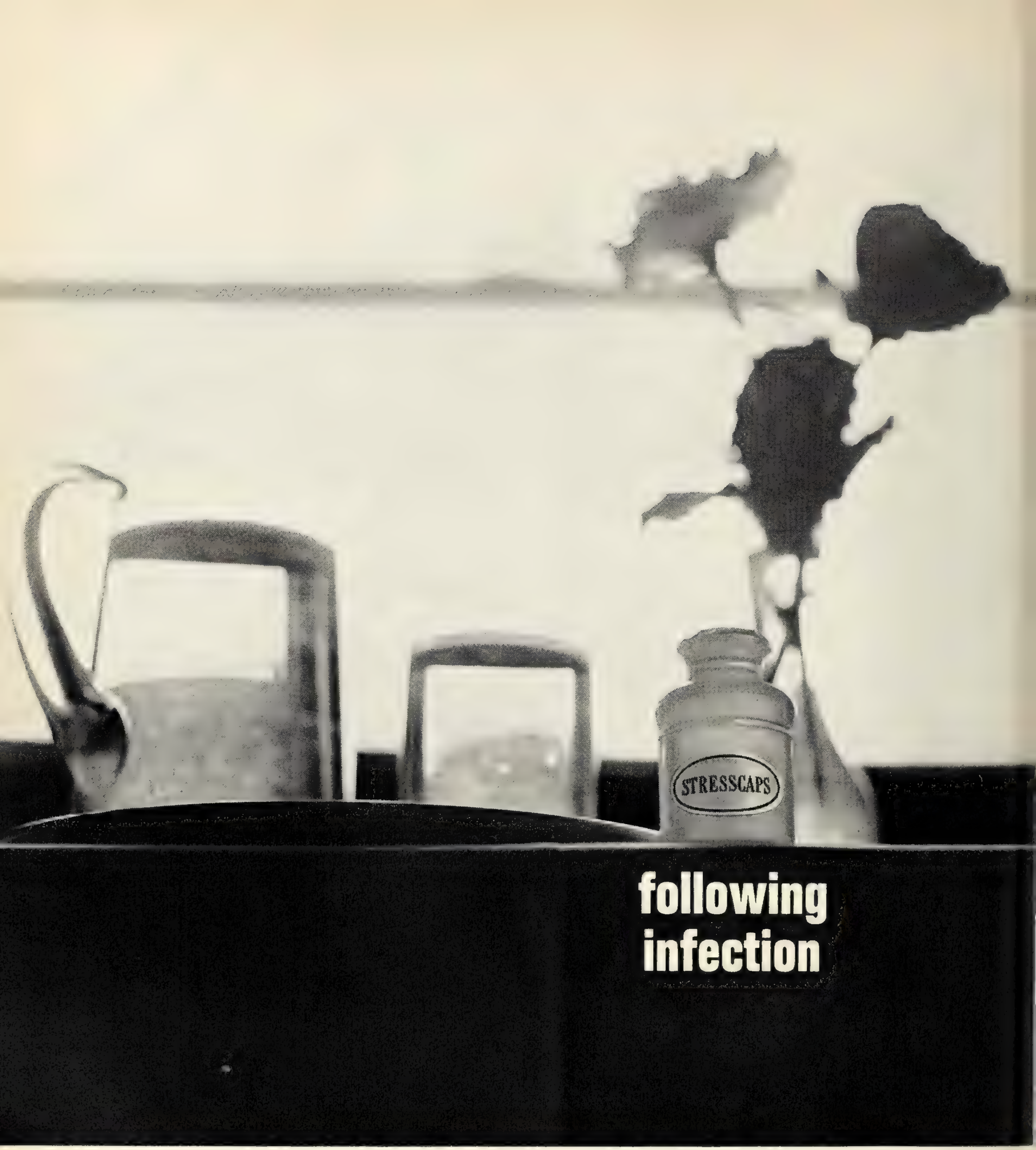

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ANCILLARY SECTION

"Mother and Fetus" Symposium, Nov. 10-11, WSU

A symposium on the physiology and pathology of reproduction, "Mother and the Fetus," sponsored by the Wayne State University Department of Obstetrics and Gynecology and Harper Hospital, will be held November 10 and 11 at the hospital's Morse Auditorium.

The program includes a reception and dinner on November 10 at the Wayne County Medical Society headquarters.

The two-day program will include a reception and dinner on November 10 at the Wayne County Medical Society headquarters. Dinner speaker will be Ernest W. Page, M.D., professor and chairman, Department of Obstetrics and Gynecology, Tufts University School of Medicine. His topic will be: "Evolution of the Human Placenta."

Other November 10 speakers and their topics:

"The Structure and Function of the Fallopian Tube: A Correlative Review"—Luigi Mastroianni, Jr., M.D., professor and chairman, Department of Obstetrics and Gynecology, University of Pennsylvania.

"Placental Endocrine Functions"—Kenneth J. Ryan, M.D., professor and chairman, Department of Obstetrics and Gynecology, Western Reserve University.

"Physiologic Studies Related to the Fetus In-Utero"—Harry Prytowsky, M.D., professor and chairman, Department of Obstetrics and Gynecology, University of Florida.

"Fetal Life In-Utero and the Changes at Birth"—N. S. Assali, M.D., professor, Department of Obstetrics and Gynecology, The Center for Health Sciences, Los Angeles.

"Effects of Drugs on Pregnancy and the Fetus—Some Experimental Observations"—James C. Wilson, M.D., professor and chairman, Department of Anatomy, University of Florida.

Participants for November 11 and their topics:

"The Conceptus as a Homograft"—George W. Mitchell, Jr., M.D., professor and chairman, Department of Obstetrics and Gynecology, Tufts University.

"Perinatal Sequela of Drugs and Anesthetic Agents"—Virginia Apgar, M.D., director, Division of Congenital Malformations, Medical Scientific Research Department, The National Foundation March of Dimes.

"The Clinical Use of Urinary Excretion of Estriol and Preliminary In Vitro Studies of Estrogen Production of the Placenta of Abnormal Pregnancies"—John W. Greene, Jr., M.D., professor and chairman, Department of Obstetrics and Gynecology, University of Kentucky.

"Immunologic Phenomena in Infertility and Their Practical Applications"—S. J. Behrman, M.D., professor, Department of Obstetrics and Gynecology, University of Michigan.

"The Price of Prematurity"—Nicholson J. Eastman, M.D., professor emeritus of Obstetrics, Johns Hopkins University.

A seminar paper will also be delivered by Paul D. Bruns, M.D., professor, Department of Obstetrics and Gynecology, University of Colorado.

AMA Health Guide Offers Sound Advice

Sound and authoritative advice is the hallmark of *Today's Health Guide.* The American Medical Association spared no effort in making *Today's Health Guide* the finest book of its kind available.

The AMA drew upon the most brilliant medical minds in the world to prepare *Today's Health Guide;* over 200 physicians, surgeons, educators, psychologists, clergymen, and medical writers contributed to the book, and the completed manuscripts were reviewed by others equally talented. Final editing was done by an AMA board of staff physicians and writers who have spent their professional life developing health information literature for the general public as well as for doctors.

The publication deals with the following subjects:

Home is a Health Center
Health and Your Family
Safety
Surgery Today
The Wonderful Human Body
When You Need a Doctor
Public Health
Good Drugs and Bad Drugs
Mental and Emotional Illness
Dangerous and Disabling Diseases
Physical Handicaps
Recreation and Relaxation
Safeguarding Your Health
Medical Services for the Family
Keeping Posted

Mental Health Series Offered By Wayne

Unprecedented opportunities and approaches for new advances in the field of mental health, resulting from recent national, state and local programs and legislation, will be discussed in a series of eight monthly classes, "New Developments in Community Mental Health," sponsored by the Wayne State University Department of Psychiatry and Detroit General Hospital.

The series, designed for physicians, behavioral scientists and members of other professions working in the mental health field, will be conducted at Herman Kiefer Hospital. Classes begin October 8 and will include lectures by visiting community health authorities, small group workshops and luncheon sessions.

Henry Krystal, M.D., clinical assistant professor of psychiatry at WSU, is director of the series.

Registration forms and information can be obtained from Henry Krystal, M.D., Continuing Psychiatric Education Department, Herman Kiefer Hospital, 1151 Taylor Street, Detroit. The $40 fee for the eight sessions covers luncheons and registration.

October 8—Community Psychiatry— Small Group Theory I, lecture by Harris B. Peck, M.D., Associate Professor of Psychiatry, Albert Einstein College of Medicine, and Director of Psychiatric Services, Lincoln Hospital, Bronx, New York.

November 12—Addiction, A Community Problem: Implications for Treatment, lecture by Dale C. Cameron, M.D., Superintendent, St. Elizabeth's Hospital, Department of Health, Education & Welfare, Washington, D. C., and Clinical Professor of Psychiatry, George Washington University.

December 10—Planning and Development of Social and Community Psychiatry by the Federal Government, lecture by Leonard J. Duhl, M.D., Chief of Planning Staff, National Institute of Mental Health, Bethesda, Maryland.

January 14—Group Theory and Residential Treatment, lecture by Fritz Redl, Ph.D., Distinguished Professor of Behavioral Science, Wayne State University College of Education.

February 11—Short-Term Psychiatry, lecture by Lewis R. Wolberg, M.D., Clinical Professor of Psychiatry, New York Medical College and Flower Hospital.

March 11—Rehabilitating the Community: Working with the Community and the Individuals in It, lecture by Mildred Peters, Ph.D., Professor of Education in Guidance and Counseling, Wayne State University College of Education, and The Individual and the Group, lecture by Alvin Zanzer, Ph.D., Director of the Research Center for Group Dynamics, University of Michigan.

April 15—Emergency Psychiatry, lecture by Leon Hankoff, M.D., Director of Psychiatry, Queens Hospital Center, Jamaica, New York, and Assistant Professor of Psychiatry, State University of New York.

May 13—Interaction of Research and Service in Community Mental Health, lecture by Melvin Sabshin, M.D., Professor and Chairman, Department of Psychiatry, University of Illinois at the Medical Center, Chicago.

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U-M Postgraduate Medicine Calendar

Continuous Programs

Pathology, October 4-December 17, 1965
Physical Medicine for the Clinician, November 18-19, 1965
Otorhinolaryngology for Generalists, December 2-4, 1965
Physiology, January 10-14, 1966
Surgical Anatomy, January 17-February 25, 1966
Pediatrics, January 17-19, 1966
Obstetrics & Gynecology, January 19-21, 1966
Psychiatry, January 19-21, 1966
Renal Disease, Hypertension & Vascular Disease, January 31-February 4, 1966
Nuclear Medicine, February 7-9, 1966
Diseases of the Blood, February 14-18, 1966
Obstetric & Gynecologic Anatomy, February 28-March 11, 1966
Diseases of the Heart, February 28-March 4, 1966
Obstetric and Gynecologic Pathology, March 14-25, 1966
Clinical Immunology, March 21-23, 1966
Rheumatology, March 24-25, 1966
Electrocardiographic Diagnosis, March 28-April 1, 1966
Diagnostic Radiology, March 28-30, 1966
Blood Coagulation Techniques, April 4-8, 1966
Pulmonary Diseases, April 11-13, 1966
Otorhinolaryngology Conference, April 14-16, 1966
Ophthalmology Conference, April 18-20, 1966
Endocrinology & Metabolism, April 18-22, 1966
Recent Advances in Therapeutics, April 25-29, 1966

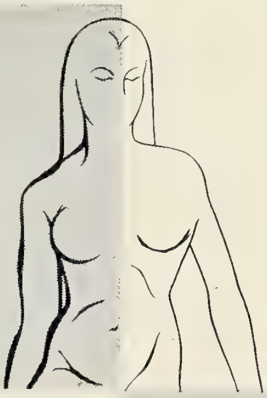
Intermittent Programs

Selected Clinical Topics in Internal Medicine (Tuesday Evenings), January 4-April 12, 1966
Anatomy (Thursdays), January 20-May 5, 1966
Psychiatry for Internists, February 16-May 4, 1966

Hemophilia Unit Offers Consultation

The Medical Advisory Council for the Michigan Chapter of the National Hemophilia Foundation will offer a consultation service to the doctors of the state by telephone or by letter.

The council also reports that the Michigan Department of Health is putting out a much larger size unit of the anti-hemophilic globulin. This will now be 2 gm and make up to 150 ml as opposed to the previous preparation which was a 50 ml, 500 mg specimen. This larger preparation will be easier, the council says, to put into solution with the addition of distilled water and will be more effective.



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New State Laws Interpreted

By Michigan Department of Health

Physicians have new legal responsibilities related to phenylketonuria and chest x-rays as a result of action taken by the last session of the state legislature. Following is a brief summary of these measures together with others of interest:

PKU Testing—Act No. 119

This act states, in part, that "it shall be the duty of any physician in charge at the birth of any infant to administer or cause to be administered a phenylketonuria test approved by the state health commissioner and to report the results of the test to the parents or guardian of the infant; and such test shall be administered before the infant is discharged from its place of birth or within such times and under such conditions and regulations as shall be prescribed by the state health commissioner."

The act goes on to authorize the state health commissioner to develop rules and regulations for the enforcement of the act.

The purpose of this bill is to assure the detection of PKU as early in life as possible so that effective action can be taken to prevent the otherwise irreversible mental retardation that would result from this metabolic disorder. If the incidence of this disease is, as now indicated, about one in 10,000 children, some 15-20 infants will be born each year in Michigan with this condition.

Rules and regulations with regard to the administration of the test as well as the laboratory procedures involved are now being developed. The legislature has also augmented the appropriation for the Division of Laboratories to enable it to process all such specimens submitted to the state health department.

Confidential Reporting of Chest X-ray Interpretation—Act No. 123

Section 20 of this public health appropriation bill states, in part, that "As a condition of making the appropriations herein contained for the protection of the public health from tuberculosis, every licensed member of the healing arts, hospital, and/or laboratory taking chest x-rays shall report all findings compatible with the suspicion of pulmonary tuberculosis to the state health commissioner on forms to be provided by him. Such reports of x-ray findings made to the state health commissioner shall be considered confidential and not as public records. The state health commissioner may promulgate and enforce such rules as are needed to carry out this section. . . ."

It is anticipated that this matter of confidential reporting will be handled in much the same manner as is the confidential reporting of positive laboratory tests done in conjunction with the diagnosis of venereal disease.

Tuberculin Testing—Act 29

As reported in an earlier issue of MICHIGAN MEDICINE, this merely adds the tuberculin test to the so-called school checkpoint law already on the books. Essentially this means that the tuberculin status of each entering school child shall be determined along with his immunization status.

It provides further that, as with immunizations, parents have the option of having this done by the private physician, requesting that it be done by the local health department, or refusing to have it done because of religious or other reasons.

Other Legislation

Other legislation of interest to practicing physicians includes bills which make it mandatory that every county in the state be covered by a local health department; an increase from $350,000 to $1,183,000 in state aid to local health departments, distributed under a new formula based on population; the appropriation of state funds to provide drugs to prevent the recurrence of rheumatic fever; an enabling act to permit family planning clinics in local health departments; an appropriation to begin work on a cancer products laboratory at the state health department; provision of a strong state program of air pollution prevention and control through the state health department; and a bill which provides for an initial registration of under-four-bed nursing homes.

The reorganization of state government bill was also another important step taken by the legislature. Under this bill, a Department of Public Health will become one of the 19 principal departments of state government. The new department will encompass all of the present activities of the state health department, together with the functions of the present Crippled Children Commission, Board of Alcoholism, and the state Veterans' Facility at Grand Rapids.

AMA Sports Conclave November 28 in East

The seventh National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association Committee on the Medical Aspects of Sports, will be held in Philadelphia, November 28.

The conference will cover a wide range of subjects of interest to physicians, especially those serving school and college sports programs.

Hospital Relations As Seen by AMA

The MSMS Council has requested the reproduction in Michigan Medicine for every member two reports from AMA Committees regarding hospital relations.

The MSMS Hospital Relations Committee recommended the publication of the statements.

First is a copy of the report from the AMA Reference Committee on Insurance and Medical Service.

Supplementary Report A of the Committee on Medical Practices: "Arbitrary Restrictions by Hospitals Against General Practitioners and Other Non-Specialists." Your Reference Committee shares the concern of the Committee on Medical Practices about the alleged departures from the standards adopted by the Joint Commission on Accreditation of Hospitals.

Your Reference Committee joins with the Committee on Medical Practices in commending the Joint Commission on Accreditation of Hospitals for publicizing its statement that "general practitioners should have the opportunity to practice medicine as active staff members in hospitals and should have granted to them such hospital privileges as their training and demonstrated skills indicate." It is recognized that the Joint Commission on the Accreditation of Hospitals is promoting this concept. Assurance has been given that the JCAH surveyors will make a more concerted effort to obtain information as to whether a hospital grants privileges in its clinical departments only to those physicians who are specialty certified or certification eligible, or who are members of specialty societies.

Your Committee welcomes the assurance that the Joint Commission on Accreditation of Hospitals will use this information in determining whether or not a hospital is entitled to accreditation. Your Reference Committee believes that this is an important factor but in and of itself should not be the sole basis for denial of accreditation.

Mr. Speaker, in view of the above information, I move that no action be taken on Supplementary Report A of the Committee on Medical Practices.

No action was taken on the above motion and the following substitute motion was adopted:

Mr. Speaker, in view of the above information, I move that hospital staffs, county societies, and state medical associations be informed of this assurance by the Joint Commission on Accreditation of Hospitals and this conviction of the House of Delegates; and that members of these staffs and societies be requested to *submit to the JCAH in writing any situations where arbitrary restrictions by hospitals against general practitioners and other non-specialists is, or may be, occurring or appears about to occur.*

I further move that a copy of such communications be sent to the American Medical Association to be recorded by the Committee on Medical Practices of this House for the continuing information of the House of Delegates.

* * *

The next report is the Report of the AMA Committee on Medical Practices:

In establishing the Committee on Medical Practices in November, 1955, the AMA House of Delegates instructed "this committee to use its full influence to discourage any arbitrary restrictions by hospitals against general practitioners as a group or as individuals." In the same resolution, the House instructed "the (AMA) representatives on the Joint Commission on Accreditation of Hospitals . . . *to stimulate action by that body leading to the warning, provisional accreditation, or removal of accreditation of community or general hospitals, which exclude or arbitrarily restrict hospital privileges for generalists as a class regardless of their individual professional competence, after appeal to the Commission by the county medical society concerned.*"

Since the preparation of its annual report for 1964 (Handbook of the House of Delegates, Clinical Session, 1964, pages 361-362), it has been brought to the attention of the Committee on Medical Practices that arbitrary discrimination by hospitals against general practitioners and other non-specialists is more widespread than is generally believed by the medical profession. This discrimination is in direct conflict with the letter and spirit of the principles of the Joint Commission on Accreditation of Hospitals. (Handbook of the House of Delegates Clinical Session, 1964, page 325, which states "that general practitioners should have the opportunity to practice medicine as active staff members in hospitals and should have granted to them such hospital privileges as their training and demonstrated skills indicate.)

The Committee on Medical Practices wishes to commend the JCAH on their stand. However, the Committee would like to call to the attention of this House that hospital bylaws have been found which specify that privileges in their clinical departments will be granted only to those physicians who are specialty certified or certification eligible, or who are members of specialty societies.

The Committee on Medical Practices believes that arbitrary discrimination by hospitals against general practitioners is creating a division within the ranks of American medicine. This is harmful to the public which American medicine serves. We need to present a united effort to keep the supply of medical care adequate with free choice to those who wish to utilize the talents of general practitioners and other non-specialists.

Accordingly, the Committee on Medical Practices requests the House of Delegates to instruct the AMA representatives on the Joint Commission on Accreditation of Hospitals to take cognizance of the existing widespread discrimination by hospitals against general practitioners and to work towards action by JCAH leading to provisional accreditation or removal of accreditation of community or general hospitals which do not extend hospital privileges to all qualified physicians according to experience, judgment, ability, and competence. The Committee on Medical Practices firmly believes that such action by the House of Delegates is necessary at this time and would effectively implement the repeatedly expressed policy of the House of Delegates.

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NEW DRUG AMENDMENTS FOR '66 EXPLAINED

By Robert J. Johnson, R.Ph.
Executive Secretary
Michigan State Pharmaceutical Association

The new drug amendments of 1965 have been signed into law by President Johnson and will take effect February 1, 1966.

A pamphlet entitled "HR 2 and You" explaining the new amendments and indicating what pharmacists and physicians must do to comply has been prepared by the American Pharmaceutical Association. A copy of this brochure may be obtained from your local pharmacist or by writing the American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D. C. 20037.

Highlights of the new law are as follows:

Drugs Covered

Barbiturates and amphetamines are specifically named in the bill. In addition, the secretary of HEW may include additional stimulant and depressant drugs under the bill by regulation. (It is expected that certain tranquilizers will eventually be included.)

Records

All health practitioners handling stimulant and depressant drugs must prepare a complete inventory of all stocks on hand as of February 1, 1966, and keep the inventory for three years. Thereafter, a record must be maintained of all drugs received and dispensed. This record must be maintained for three years.

Inspection

The record of receipt and disposition of depressant and stimulant drugs must be available for Food and Drug Administration inspectors.

Professional Samples and Physicians

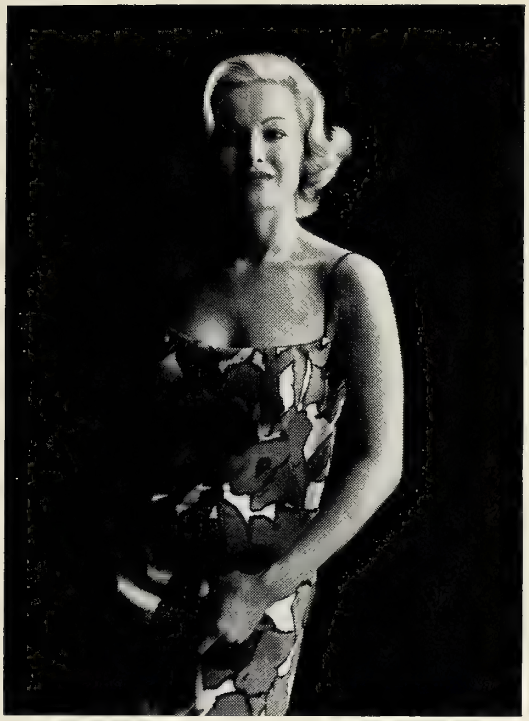
Records must be made of professional samples of stimulant or depressant drugs obtained from medical representatives. The medical representatives must also maintain a record of samples given to pharmacists or physicians.

Physicians who regularly engage in dispensing stimulant or depressant drugs to their patients must also keep records of receipt and disposition and make them available for inspection.

Prescription Orders and Renewals

Prescriptions for depressant and stimulant drugs may be given by oral or telephone order according to the usual practice. However, no prescription order can be renewed more than *five times* and no prescription order can be dispensed or renewed more than *six months* after the date of issue.

Say you saw it in Michigan Medicine



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Most overweight patients could benefit from the appetite control provided by the prolonged anorexigenic-tranquilizing action of BAMADEX SEQUELS: anorexigenic action through the central stimulant effect of the amphetamine; tranquilizing action with only mild sedation through meprobamate; prolonged action through sustained release of active ingredients.

Contraindications: Hyperexcitable and prepsychotic states; patients hypersensitive to meprobamate.

Side Effects: Occasional allergic skin reactions may occur with meprobamate, accompanied by fever, nonthrombocytopenic purpura, angioneurotic edema, hypotension, or bronchial spasm. Drowsiness with or without ataxia and/or alteration in visual accommodation may occur. Effects of alcoholic beverages may be increased by meprobamate. Use with caution in patients with coronary or cardiovascular disease or severe hypertension. Prolonged use may result in dependence. Reactions can occur if drug is not withdrawn gradually.

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He Asks: Are Generalists Now A Vanishing Species?

By Brooker L. Masters, M.D.
Fremont
MSMS Councilor

Who am I? I am a Doctor of Medicine. I never write "M.D." behind my name but what I get a thrill—and remember that first time when I was an interne and the hospital call system said "Doctor Masters . . . !" (The thrill is even greater today.) I am licensed "to practice medicine, surgery in all their branches in the State of Michigan."

And I do.

I deliver babies. I do their pediatric care—immunizations, fevers, anemias, broken bones—you name it. Yes, I have even watched some of "my babies" grow up until now they are having babies of their own. And I've seen some of them die so tragically of leukemia and heart disease . . .

* * *

I HELP THE young couples have their children, and then help them raise them in the best way we know to provide this country with its future citizens. And I help the young couples stay together. Family counselling is an intimate part of my work. There are very few who need a psychiatrist; but there are many emotional problems I can help with.

I do surgery I am capable of—and I would put our success-failure records up against any. I handle acute coronaries, new cases of diabetes, and common cold, and Johnny's temperature of 104° at 1 a.m. I have seen my friends die of cardiac decompensation, cancer, and just old age. And I try to explain to their families "why." It is a privilege of the highest order to be there at the birth of a human life, watch it grow and mature, and help it to face, with honor and equanimity, the inevitable decline and death . . .

I have been called many names: family physician, general practitioner, generalist—but I choose to believe I am just a doctor, as my medical school wanted me to be when it turned me out in 1942. I find that my patients appreciate having a doctor they can call on for most anything. If I cannot do it, they know I can refer them to the competent specialist who can. It is a very rewarding experience for both patient and doctor.

* * *

UNFORTUNATELY, I am many times saddened when I think of my future. Not for myself, but because I am a member of a vanishing species. Just as surely as James Fenimore Cooper described "The Last of the Mohicans," just as surely are there very few coming along to follow in my footsteps. It is not a pleasant thought to consider that one is a member of a vanishing race, but you know as well as I do, that this is true.

* * *

Strange, isn't it? I am the happiest doctor in the U.S.A., my patients think they are getting good and complete medical care, and the medical profession says "we need more like you!"—yet, I am a vanishing phenomenon!

* * *

THERE ARE specialty groups who now say they will be the general practitioners of the future, but even before they assume the role they are already setting the limits of their concern: now what will happen if the illness or injury doesn't "fit" their definition? And we all know other specialties doing "general practice" today, while telling my brethern in the city "thou shall not!"

Who am I?

Perhaps "The Last of the Mohicans" in the general practice of medicine, but somehow it seems to me that this marvelous job of being a complete doctor of medicine shouldn't be turned out to a reservation or placed in a historical museum.

What do you think?

* * *

(This article is reprinted with permission from "The Bulletin" of the Muskegon County Medical Society.)

AMA Helps Provide Medics for Viet-Nam

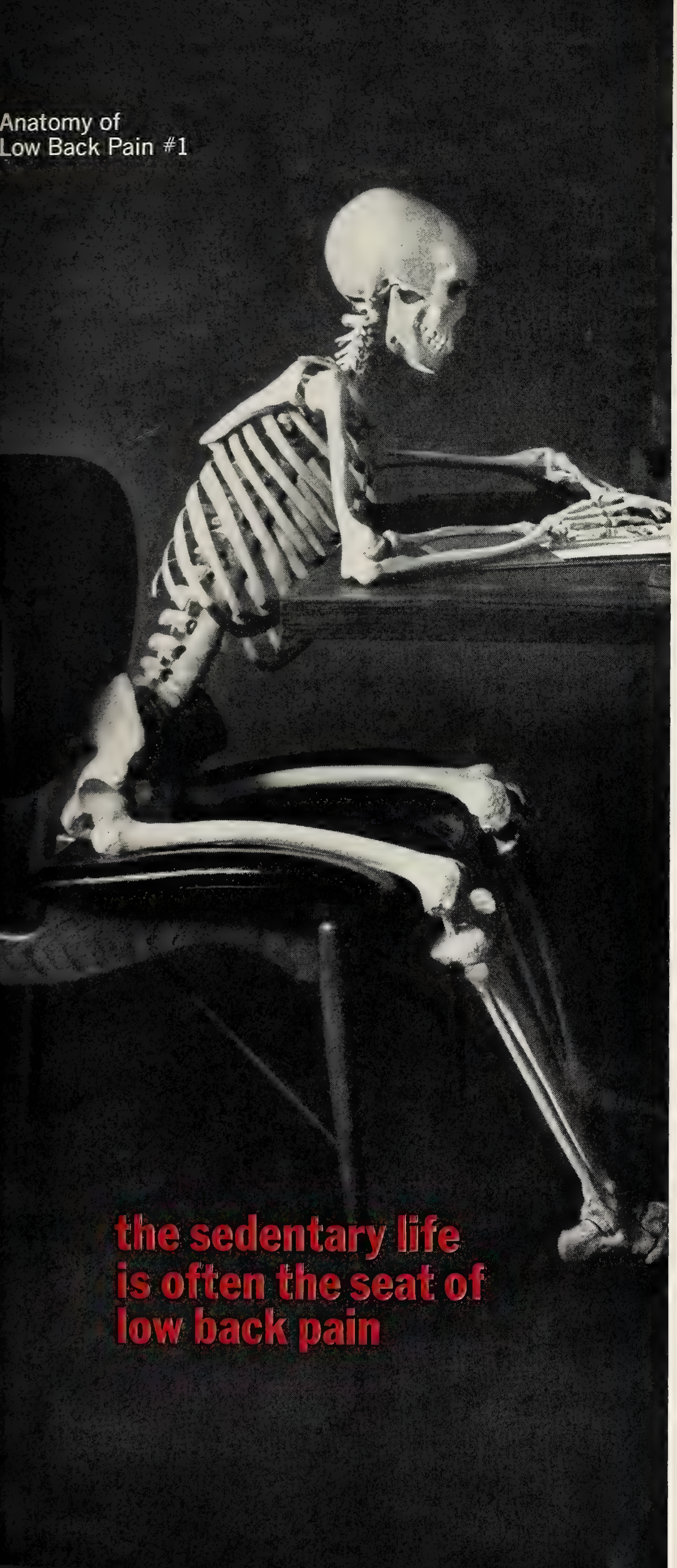
In response to an urgent appeal to American Medicine by President Johnson, the American Medical Association is assisting the newly formed voluntary organization known as PROJECT VIET-NAM.

This Project, administered by The People-to-People Health Foundation, Inc., is a cooperative medical effort of America's inter-voluntary agencies for the people of South Viet-Nam. The agency for International Development (AID) is also participating in this program that appears vital to our success in the present crisis in Asia.

PROJECT VIET-NAM was developed to help alleviate the problem of the critical shortage of physicians in South Viet-Nam—a problem that is crippling and demoralizing the civilian population of the country.

PROJECT VIET-NAM will send teams of 20 physicians into Viet-Nam for periods of 60 days.

Full details may be obtained from: PROJECT VIET-NAM, 2233 Wisconsin Avenue, N.W., Washington, D. C. 20007; phone: 338-5730 or 338-6110.



The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strains

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Hudson to Speak at U-M Alumni Event

Several hundred alumni of the University of Michigan Medical Center will return this month, Oct. 14-16, for three days of science and fellowship.

A highlight of the Medical Center Alumni Society Conference will be an address on "The Future of Medical Practice" by Charles Hudson, M.D., President-Elect of the American Medical Association.

Doctor Hudson, whose father was the only doctor in the town of Merrill, Mich., was graduated from Alma College and the U-M Medical School in 1930. He is now on the staff of Cleveland Clinic.

The conference is open to all former students in the U-M Medical School and School of Nursing, as well as those who took residency training at University Hospital.

The first day of the conference is devoted to reunions and scientific programs of individual classes and specialty groups. The second day is set aside for general scientific programs for all, special events for spouses, and a dinner-dance at Washtenaw Country Club. Doctor Hudson will speak at that day's luncheon. The last day's highlights are the reunion picnic and the U-M Homecoming football game against Purdue.

WSU Lists Tuition-free Psychiatric Seminars

Two 24-week psychiatric postgraduate seminars, one covering basic principles and applications to pediatric practice and one covering basic principles and applications to adults, adolescents and children, are being offered by the WSU School of Medicine department of psychiatry. A National Institute of Mental Health Grant covers tuition costs for both.

The seminar in pediatric psychiatry, limited to 25 pediatricians, begins November 18 and runs through April of next year. The other seminar, listed as a basic course in psychiatry, is limited to 40 physicians in general or specialty practice. Beginning date is November 16.

Advance enrollment is requested. Information can be obtained by writing to Paul Lowinger, M.D., Psychiatric Service, Detroit Memorial Hospital. Classes will meet in room 149, Lafayette Clinic.

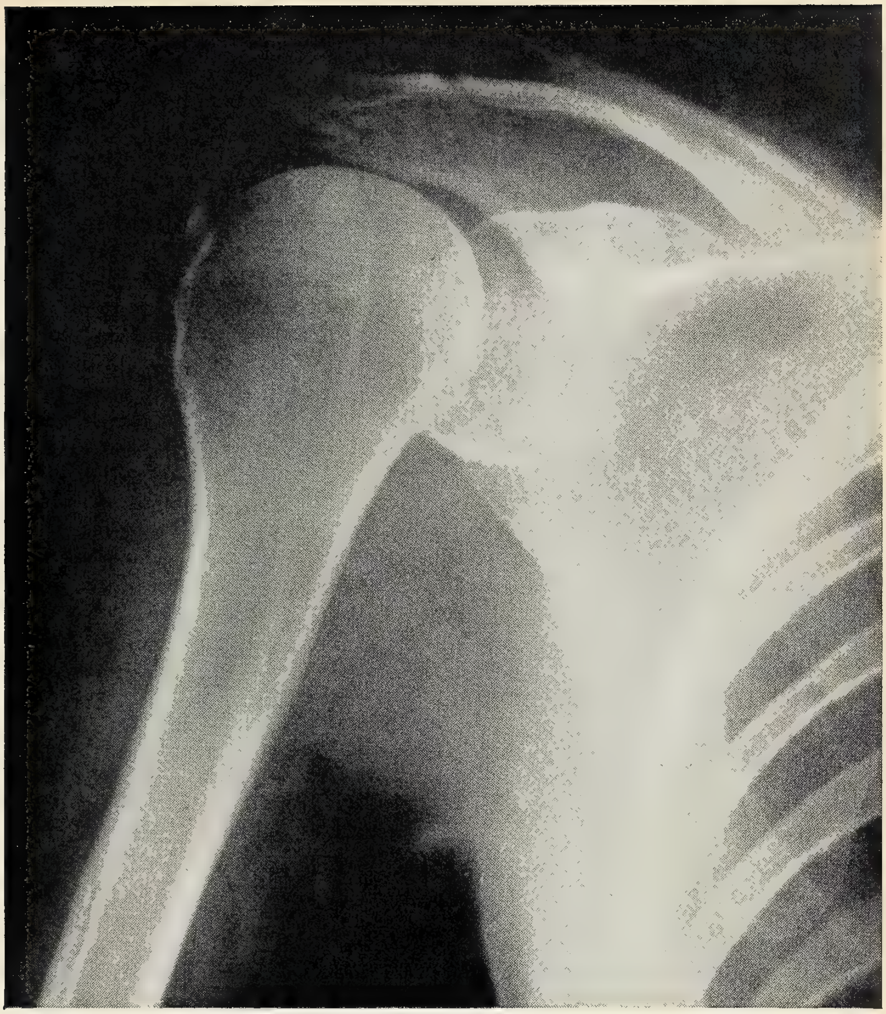
Doctor Cowan Leads National Group

John A. Cowan, M.D., director of the adult health division, Michigan Department of Health, was elected the new president of the Association of State and Territorial Chronic Disease Program Directors.

He was elected at the recent biennial convention in Cleveland.

Butazolidin®
brand of phenylbutazone

in painful shoulder



Geigy

Therapeutic Effects
The acute phase of subdeltoid bursitis, tendinitis and associated periarticular inflammation usually responds promptly and dramatically to Butazolidin, brand of phenylbutazone. Pain and tenderness may be relieved within 24-48 hours and mobility of the affected arm quickly restored. Full recovery is frequently achieved within 7-10 days so that therapy is generally of short duration. Calcific deposits are not specifically affected by treatment, but their presence does not appear to retard symptomatic improvement.

Phenylbutazone has not replaced physiotherapy, x-ray treatment, or local injections of hydrocortisone in the more chronic conditions, but it may advantageously be combined with these measures.

Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage
Initially, give 400 mg. daily (one tablet or capsule q.i.d.), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. To minimize gastric distress, Butazolidin alka capsules may be the preferred form.

Note: The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

Butazolidin alka

Each capsule contains:	
Butazolidin, brand of phenylbutazone	100 mg.
dried aluminum hydroxide gel	100 mg.
magnesium trisilicate	150 mg.
homatropine methylbromide	1.25 mg.

Butazolidin
brand of phenylbutazone
Tablets of 100 mg.

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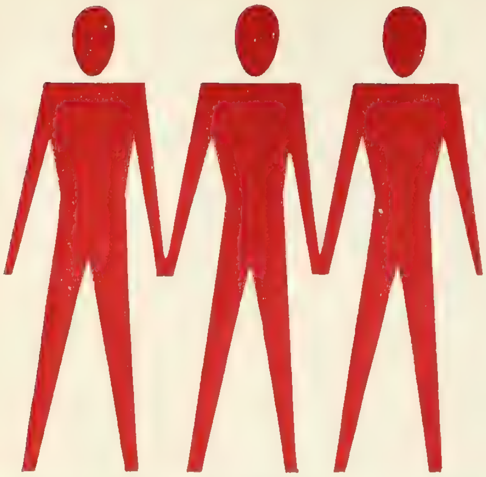


SOCIO-ECONOMIC

Federal Research Expenditures Grow

Total national funds for research and development were an estimated 16.4 billion in 1962-63. Almost three-fourths of the funds were used by industry, 16.5 per cent by Federal agencies, and 13 per cent by colleges, universities and other nonprofit institutions. The Federal Government provided 67 per cent of the funds, and industry 30 per cent.

In fiscal year 1964 Federal research and development expenditures reached an estimated $15.0 billion. (In 1958 the total was $5 billion; in 1950 it was $1 billion.)

Research and development expenditures now account for 15 per cent of the Federal budget, as compared with 5 per cent 10 years ago.

U. S. Department of Health, Education and Welfare in 1964 obligated an estimated $811 million for research and development. The Department ranks fourth among the Federal agencies in this field. The top three are the Department of Defense, National Aeronautics and Space Administration, and the Atomic Energy Commission.

Estimate 8,000 Needed to Staff Medicare

It will require an additional 7,000 to 8,000 government employees to administer the new medicare program, Wilbur J. Cohen, undersecretary of health, education and welfare, has announced. Cohen told a press conference that premiums for the supplementary medical insurance program, which is voluntary, probably will be raised within several years but expressed hope that the increase will be gradual.

PRESCRIPTIONS IN EFFECT COST LESS TODAY

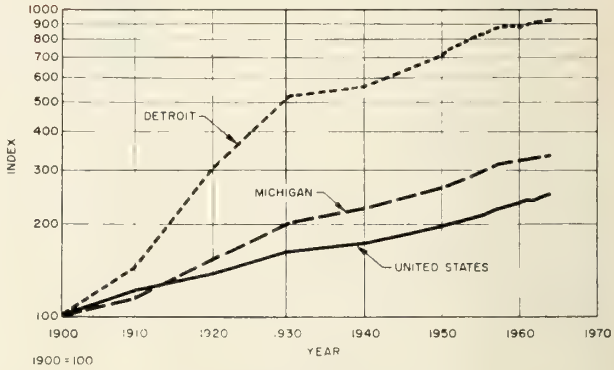
"The price of individual new drugs may seem high when they are first introduced. However, as production and distribution methods are improved and as some of the research investment is recovered, the price of new drugs invariably goes down, often dramatically if research opens the door to more efficient and productive ways to manufacture them.

"Each year, the drug industry tests more than 100,000 substances, of which only about 40 turn out to have enough value to be marketed.

"The average cost for a prescription in 1939 was 91¢. To pay for it, the average wage earner had to work 1 hour and 41 minutes. Today the average (and much more effective) prescription costs about $3.26. But to pay for it, the wage earner works only about 1 hour and 23 minutes.

"Thus today's better drugs actually take less of the medical-care dollar than the inferior drugs of 25 years ago. Furthermore, the wholesale price of prescription drugs has actually declined 10 per cent since 1949 while the wholesale price for all commodities has risen 26 per cent."

Quoted from new AMA "Today's Health Guide," available by mail at $4.95 from the AMA at 535 North Dearborn St., Chicago 60610.



MICHIGAN POPULATION CURVE TAPERS OFF

In the 60 years to 1960, Michigan's population increased 223 per cent as compared to an increase of 135 per cent for the nation. This resulted in the ratio of Michigan-to-U. S. population steadily rising from 3.18 per cent in 1900 to 4.36 per cent in 1960. Since 1960, however, the situation has been reversed. While U. S. population grew 6.7 per cent, Michigan experienced only a 4.8 per cent increase, resulting in a .13 per cent decline in state-to-nation population ratio.

In 1950, Detroit area population accounted for 17 per cent of the state total. This proportion rose to 48.1 per cent in 1960, then fell back to 47.8 per cent in 1963. From 1963 to 1964, largely because of a healthy economic climate, it gained .9 per cent to 48.7 per cent.

A.H.C.P.
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And this service begins by informing your patients about the American Health Credit Card, which permits them to pay you immediately for the health and medical services you perform.

That's the job of these American Health Credit Plan brochures contained in this attractive office and waiting room dispenser. You should have one by now, but if you don't and would like to receive the full story on how A.H.C.P. benefits you, send a note to:

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PUBLIC RELATIONS

Huron Scores With Diabetes Detection

Huron County Medical Society reports excellent results with a Diabetes Detection Exhibit at the Huron County Fair this summer.

Dextrostix tests were performed by R.N.'s and one member of the society was present at all times to interpret the tests and answer questions.

A total of 1,175 tests were performed. Those with blood glucose levels over 130 mgm per cent were referred to their family doctors for follow-up.

Pamphlets were furnished by A.D.A. and the AMA on diabetes, poisons, seat belts and diet to add interest to the fair exhibit.

Phillip R. Turner, M.D., 230 South First Street, Harbor Beach, reports that he will gladly provide details about this public-service project to any interested MSMS member or county society.

Dean Contrasts Work of Doctors With Teachers

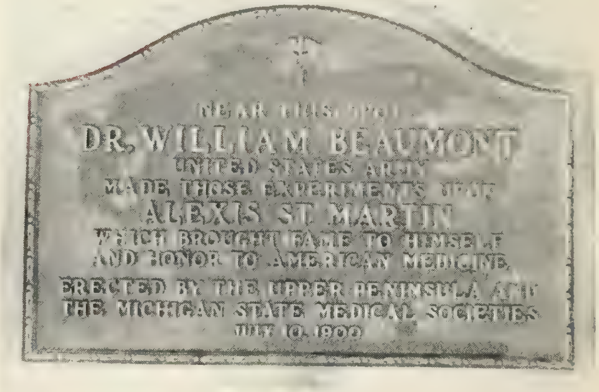
Michigan Medicine readers will be interested in some of the views about education expressed by Dean Ernest O. Melby of Michigan State University as reported in a recent issue of the *Michigan Education Association Journal.*

The Journal reported on Dean Melby's speech to the Association for Supervision and Curriculum Development Convention. In part, the Journal declared:

"In a general session address, education was compared to medicine—and critically so—by Ernest O. Melby, distinguished professor of education at MSU. 'The analogy with medicine may not be perfect,' he said, 'but the fact remains that in medicine we do all we can to save life whereas in schools we have little to offer to those who for whatever reason are unable to thrive on the school fare which the establishment provides.'

'Doctor Melby contrasted the functioning of the medical profession and the teaching profession. The doctor's first step is to find out something about his patient and diagnose his illness. The schools start teaching, often without even knowing the names of the pupils. In medical practice the gravely ill patient gets the most attention; in the schools attention is parceled out equally among 30 or 35 children.

"Doctors do all they can to save life, Doctor Melby said, even when the evidence points toward failure; schools often confront the pupil with tasks, knowing in advance that failure is ahead, and are relieved when the failing pupil leaves school. Generally speaking, in medicine, the ablest physicians tend to get the most seriously ill patients; in schools the most serious cases usually get the least able teachers, while the ablest teachers seek out the academically talented pupils."


NEAR THIS SPOT
DR. WILLIAM BEAUMONT
UNITED STATES ARMY
MADE THOSE EXPERIMENTS UPON
ALEXIS ST MARTIN
WHICH BROUGHT FAME TO HIMSELF
AND HONOR TO AMERICAN MEDICINE.
ERECTED BY THE UPPER PENINSULA AND
THE MICHIGAN STATE MEDICAL SOCIETIES
JULY 10, 1900

Historic Markers by County Societies Are Good Projects

The MSMS Centennial has encouraged the study of medical history by several county medical societies. Several are considering the possibility of erecting a historic marker during the coming year to commemorate a medical event in their own county.

MSMS is curious about the historic markers which have been erected in the state by county societies.

One of the markers of this nature that is perhaps best known is the one placed by the Upper Peninsula Medical Society and MSMS together in 1900 to mark the Beaumont experiments at Fort Mackinac on Mackinac Island.

REREGISTRATION SOON

MSMS members should watch in November for their annual reregistration forms from the Michigan State Board of Registration in Medicine.

These must be returned to the State Board with the $5.00 fee before December 31.

Hints on Working With the Press

That's right! The newspaper doesn't make the news. It's your county medical society organization that does. One of the uphill struggles facing newspapers and their staffs is to convince all community groups that the newspapers only report or interpret the news.

They don't make news.

For a quick understanding about what is news, here's a broad, simple definition:

"News is anything and everything of interest to the public." And certainly health is of interest to everyone.

Generally the news stories will get into print if they answer two questions: (1) Is it factual? (2) Is it about something in the public interest?

* * *

SOME INSIGHTS into newspaper operation that will be valuable are: (1) Newspapers have deadlines, which must be respected. (2) News is news today only, not tomorrow. (3) Newspapers generally are short-handed; any help will be sincerely appreciated. (4) Newspapers are always looking for human-interest photos and news features.

In approaching a newspaper, the county society president or public relations chairman should introduce himself to the editor, the managing editor or the city editor.

* * *

HERE IS AN excellent opportunity to seek professional advice. The editor, or the reporter, can give you some solid suggestions. And he will have a keener interest in your group and its efforts, if he has helped make some of the plans and decisions.

The editor will introduce you to the reporter assigned to cover such groups as yours or such activities as you have planned. Some of the larger daily papers in Michigan have a science writer who specializes in medical and science news.

Every effort should be made to build a businesslike friendship with the reporter. Keep him posted on your activities. Tip him off, too, on other stories. He'll appreciate your interest.

In dealing with newspapers and other media, success generally will be due to insistence that information be factual. Do not exaggerate to secure a story. Do not mislead the reporter, editor or the public.

* * *

STORIES about local people and local efforts are not likely to be tossed aside, but do not protest if your pet articles are cut.

In closing, develop the habit of telling what will be happening, rather than reporting old events. Look ahead.

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Reporting As Ordered

A MONTHLY COMMENTARY

By Hugh W. Brenneman

EXECUTIVE DIRECTOR

The Centennial Session was just fine as a one-time celebration of a "Century of Service in Medicine." But, in spite of the fact that it was the biggest, most elaborate, most well-attended medical scientific extravaganza ever put on in Michigan, it lacked two things as far as the purposes of the MSMS are concerned: It lacked longevity and it lacked widespread community participation.

The question of how to supply these two missing elements was considered by The Council several months before the Centennial Session was held. It came up with the idea of the Healthmobile.

This, in effect, was The Council's answer to the need for a health-educational museum. At least it was a good temporary answer and far less expensive than the more cumbersome "Health Fair" originally proposed.

You will probably be hearing about the Healthmobile for a long time. It has some intriguing statistics and it has already become the target of numerous stories.

In overall size it is 50 feet long, 12 feet wide and 10 feet high. The interior has 4,500 cubic feet, containing 26 exhibits, worth approximately $100,000. A front section of the traveling exhibit, 8′x 12′, is a complete communications studio containing microphones, amplifiers, turn-tables and tape recorders. Thus it can broadcast on its own loudspeaker within the exhibits or to a large area surrounding it through the exterior speakers.

It can broadcast directly over a local radio station and it carries television slides and films for use by local television stations. The outside of the Healthmobile has billboards and posters and a screen upon which a motion picture, projected from the inside of the trailer, can be seen and heard by those who may be waiting in line or simply gazing upon this wonderous vehicle.

It is the only traveling exhibit of its kind in the world and altogether appropriate therefore that it be originated in Michigan, the motor state.

The Healthmobile's exhibits are organized into three divisions. The first division presents a point in time about one hundred years ago when three things began in Michigan—medical research, medical education and medical responsibility. These are typified, respectively, by the work of Dr. Beaumont, the founding of medical schools and teaching hospitals, and the permanent organization of the Michigan State Medical Society.

The second division, which comprises the larger part of the interior, reviews the progress during the past one hundred years of those same three elements of medicine. Medical science and research is reviewed as it is reflected in diagnosis, surgery, drugs and preventive medicine. These come to life by the stories of such breakthroughs as the Dodrill heart-lung machine, the antibiotics—such as chloromycetin, and the blood developments made in the Michigan Department of Health Laboratories.

The story of medical education is epitomized by the great teachers and the adventures in research of both students and faculty at the University of Michigan and Wayne State University medical schools.

The contributions of veterinary medicine and the basic sciences to the health of Man is recognized in the Michigan State University exhibit. Progress of the dental profession is portrayed in the fine developments in dentistry which require the coordination of medical and dental surgery. It points to procedures which originated in Michigan and are now accepted world-wide.

The organizational "children" of the MSMS are accounted for. Its postgraduate medical education program is illustrated by a transparent woman whose innards light up at the touch of any one of a series of twenty-six buttons. The origination of Blue Shield by MSMS; the instigation of the Michigan Department of Health; the forming of the Michigan Health Council, etc., are all properly noted.

The third division symbolizes the future of medicine and carries exhibits on the future of medical science, portrayed by a specially built exhibit showing life on the Moon. Alongside this is a beautiful portrayal of the professions, symbolized by a three-foot sculpture created by the famous sculptor Marshall Fredericks. This depicts the new symbol of the Michigan Association of the Professions, i.e., Astroman—reaching for the stars in worship and wonderment. Immediately following is the health careers exhibit formulated by the Michigan Health Council and depicting the future needs in the field of medical associates.

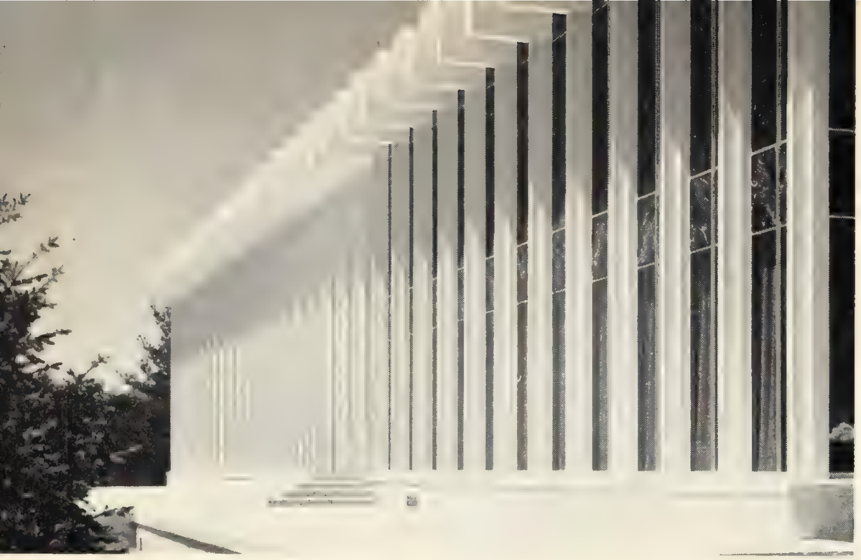
The itinerary of the Healthmobile has not yet been fully developed but present plans call for it to visit the key city in each of the fifty-five component county medical societies of the MSMS for a week-long stay.

MSMS has been fortunate in having the trailer leased to it for $1 by the Marlette Coach Company of Marlette, Michigan, manufacturers of the Marlette Trailer. The Sears Roebuck Foundation and the Michigan Health Council will collaborate to provide $10,500 for the fixtures and exhibits and Merck, Sharp and Dohme picked up a $1000 tab for the communication facilities.

Actually MSMS hopes to take its fifty-foot baby to the people and when its journeys have been completed, retire it to a Health Park.

What's a Health Park?!!??!

Well, that's another idea—for another column—for another Journal —in another month.



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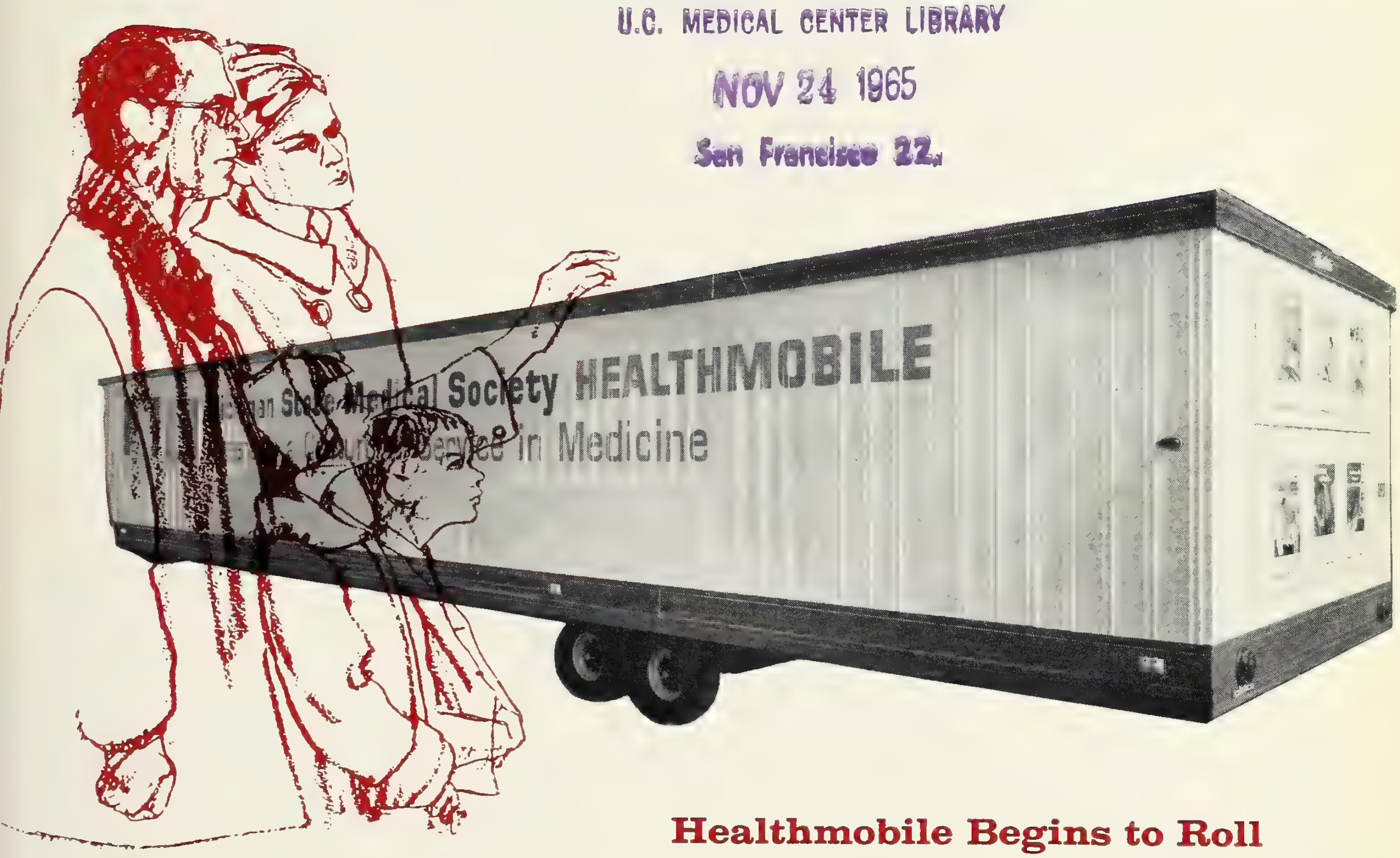
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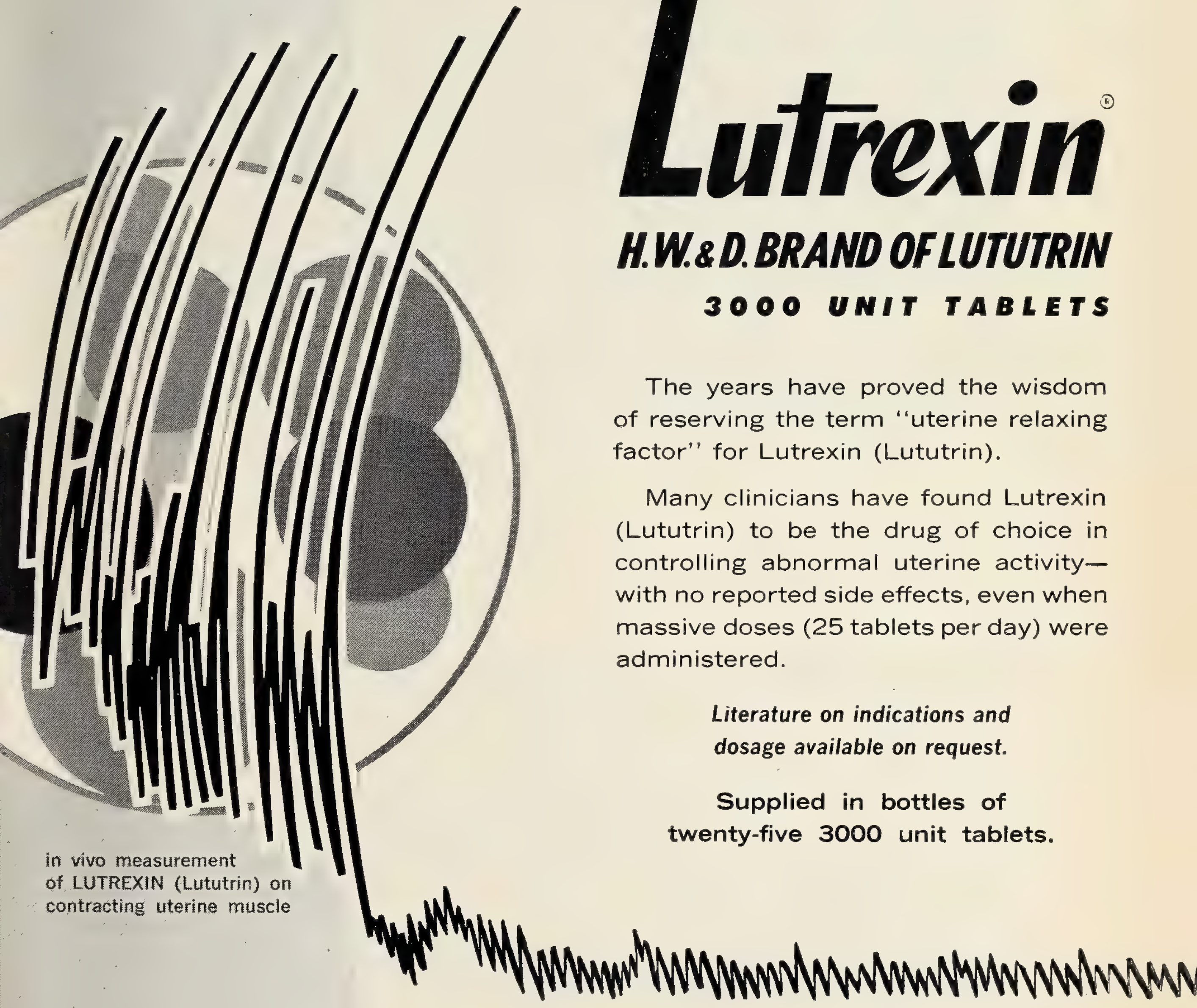

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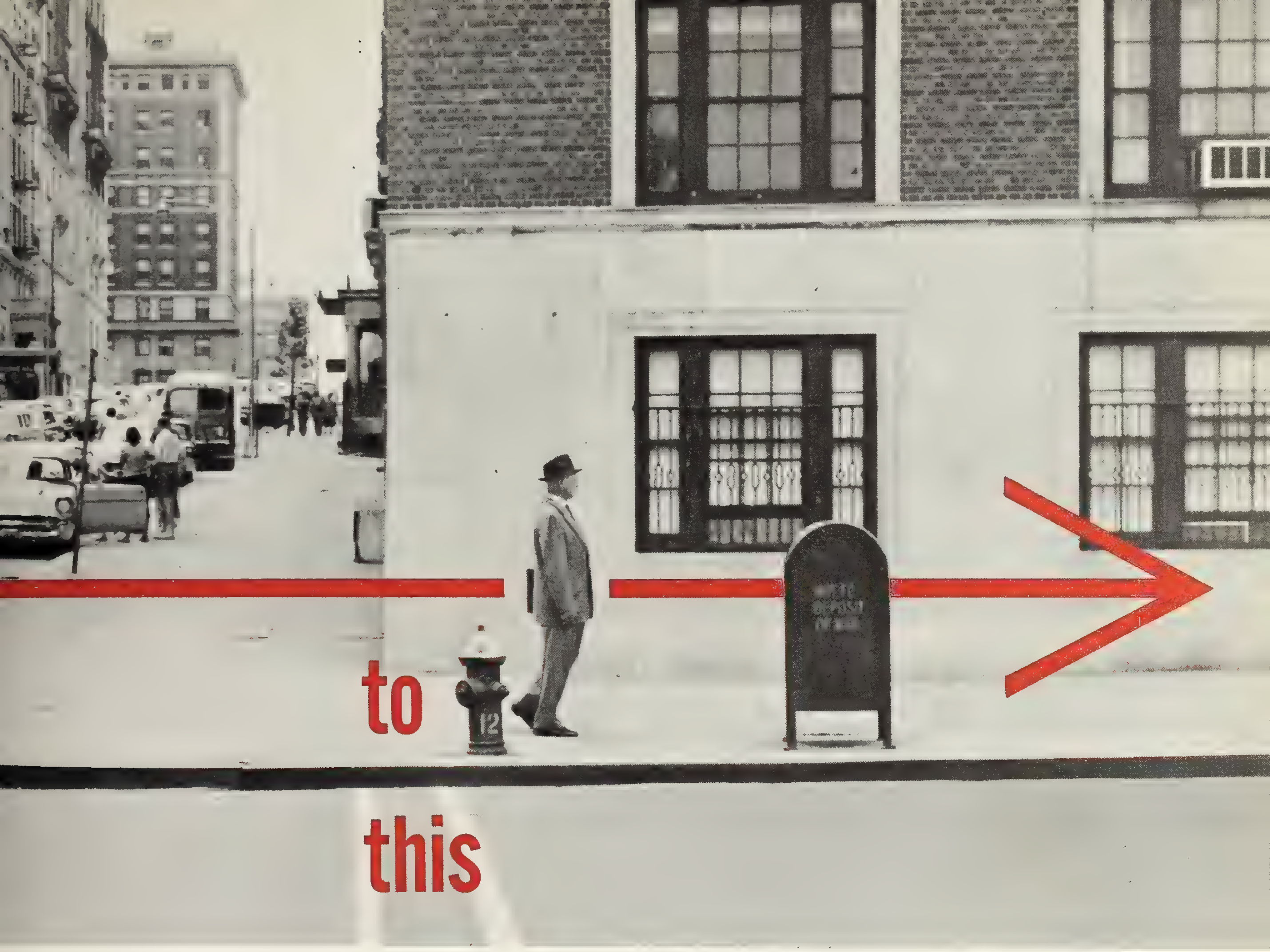

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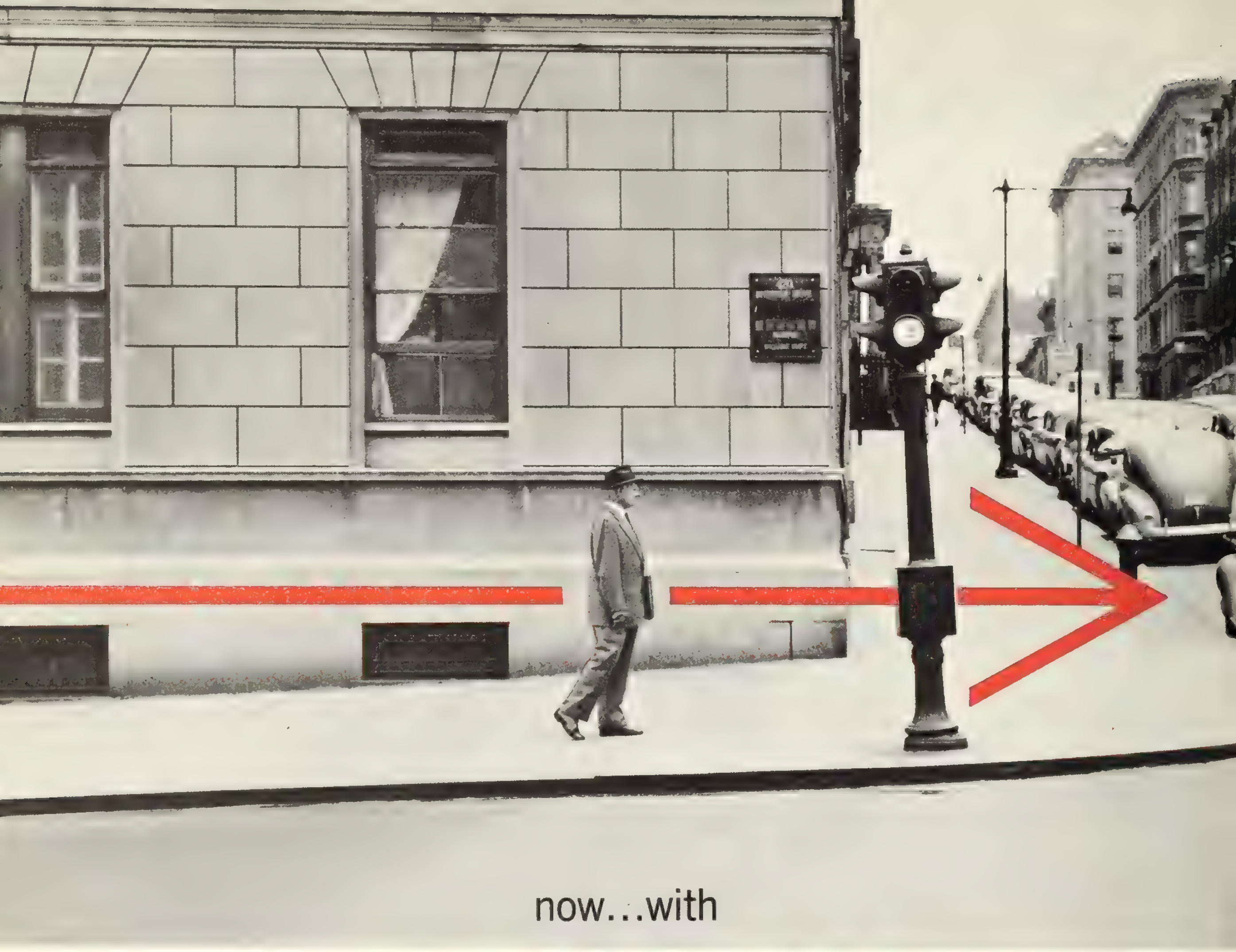

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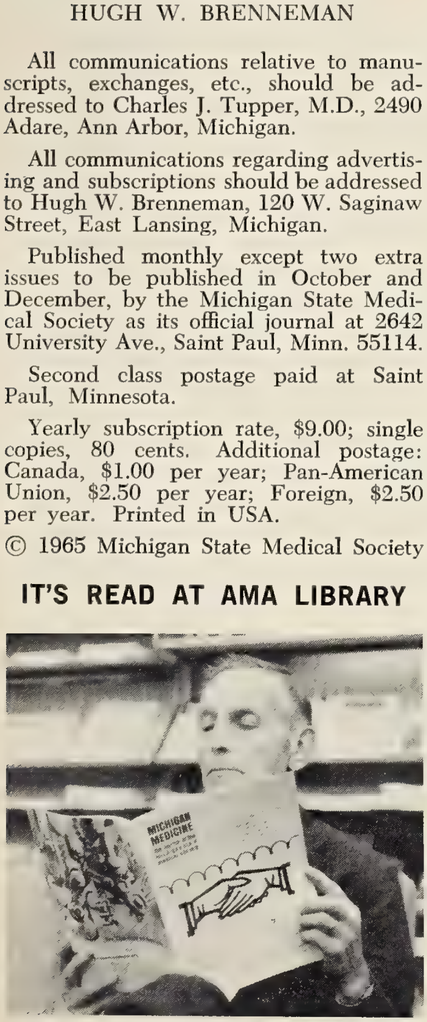
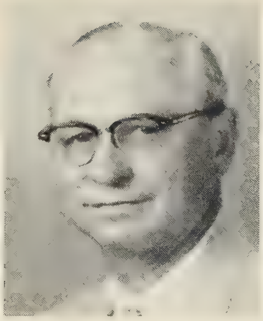




the president's message . . .

Romney Challenges Physicians

It was a personal privilege for me to introduce Governor Romney at our "Medicine and Government Day" during our Centennial Session.

Following are some of his comments urging physicians to be more active in politics and government:

"As citizens, you have the positive responsibility to do what is best for our community.

"Both political parties in this state are looking for outstanding candidates for office. Both of them are looking for more active participants, whether as candidates or not. Here's an opportunity for further service—and I hope you take advantage of it.

"I know that many of you hesitate to enter politics because you're afraid that it may hurt your practice. Do you really think it will? Will it hurt your practice any more than it does the lawyer's, for example? Will patients really reject your professional competence because you also are demonstrating political competence as a citizen? I really don't believe it.

"And even if you made an enemy here and there, or lost a patient now and then—is that too great a price to pay for entering into the full obligations of citizenship in a free society?

"You constitute a vast, largely untapped reservoir of talent for political leadership. A recent national survey of university students showed that they have more confidence in the medical profession than in any of our other social and political institutions, with the one exception of the scientific community. People look up to you. They respect you. Should you not use this position for their benefit?

"Getting involved does take courage. But it is indispensable to our survival as a free people. I urge you to be interested, not in your own narrow professional interest, but because you are citizens—because you are Americans.

"For I believe we must resist, with all our might, the present tendency of our society to become too oriented toward the Timid Man: the man who is unwilling to make moral decisions, unwilling to accept the responsibility for a decision of even slight significance—much less one of greater magnitude.

"Too many are seeking selfish security in the anonymity of the crowd, and excusing personal conduct on the basis of group action.

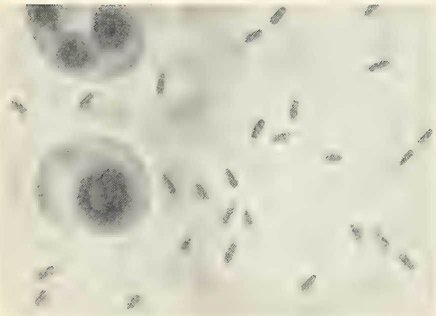
"It would be well for every American to remember the warning of Thomas Jefferson: 'Liberty is a boisterous sea. Timid men prefer the calm of despotism.'

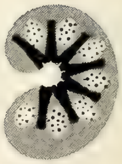
"But if free Americans do not act with personal responsibility, then individuals suffer, family life deteriorates, and our nation suffers, at home and abroad. If timidity becomes a virtue and responsible personal action becomes a thing of the past, then freedom will no longer exist, and America will be destroyed."

Well, fellow MSMS members, do we accept the challenges?

Luther R. Leader, M.D.

to clear an infected stream





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References: (1) Carroll, G.: Urologists' Letter Club, June 1, 1964. (2) McDonald, D. F., and Short, H. B.: Address to the Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, New York, Oct. 26-28, 1964.

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ADVICE TO AUTHORS:

1. Address scientific manuscripts to Editor, Michigan Medicine, C. J. Tupper, M.D., 2490 Adare, Ann Arbor, Michigan.
2. Submit original, double-spaced typewritten copy and one carbon copy on letter size (8½ x 11 inch) paper.
3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.
4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.
5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by The Journal. The Journal will pay the first $25 of the engraving bill, and the author shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.
6. References will ordinarily be limited to seven in number. Exceptions may occassionally be made.
7. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.
8. Articles should ordinarily be less than four printed pages in length (3000 words).
9. References should conform to *Cumulative Index Medicus*, including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.
10. Specify address to which galley proof should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.
11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.
12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

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Kingswood Hospital Nearing Completion

Construction of Kingswood Hospital will be completed in December and patients will be admitted beginning January, 1966. Kingswood is an in-patient facility for neuropsychiatric care developed under private auspices and located in Ferndale, a suburb of Detroit.

Sanford M. Izner, M.D., is acting as medical consultant to the board of directors. Philip N. Brown, M.D., until recently medical superintendent at Northville State Hospital, has been appointed Medical director of Kingswood. Staff appointments will be available to qualified psychiatrists in the area.

The first unit of Kingswood will have a capacity for 100 adult patients. The projected plan envisions a medical complex to include a medical-surgical extended-care facility, a professional office building, and a neuropsychiatric unit for children.

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References:
1. Schwarz, A.J.F.: Amer. J. Dis. Child., **103:** 386-389, 1962.
2. Krugman, S. et al.: Pediatrics, **31:** 919-928, 1962.
3. Andelman, S. L. et al.: J.A.M.A., **184:** 721-723, 1963.
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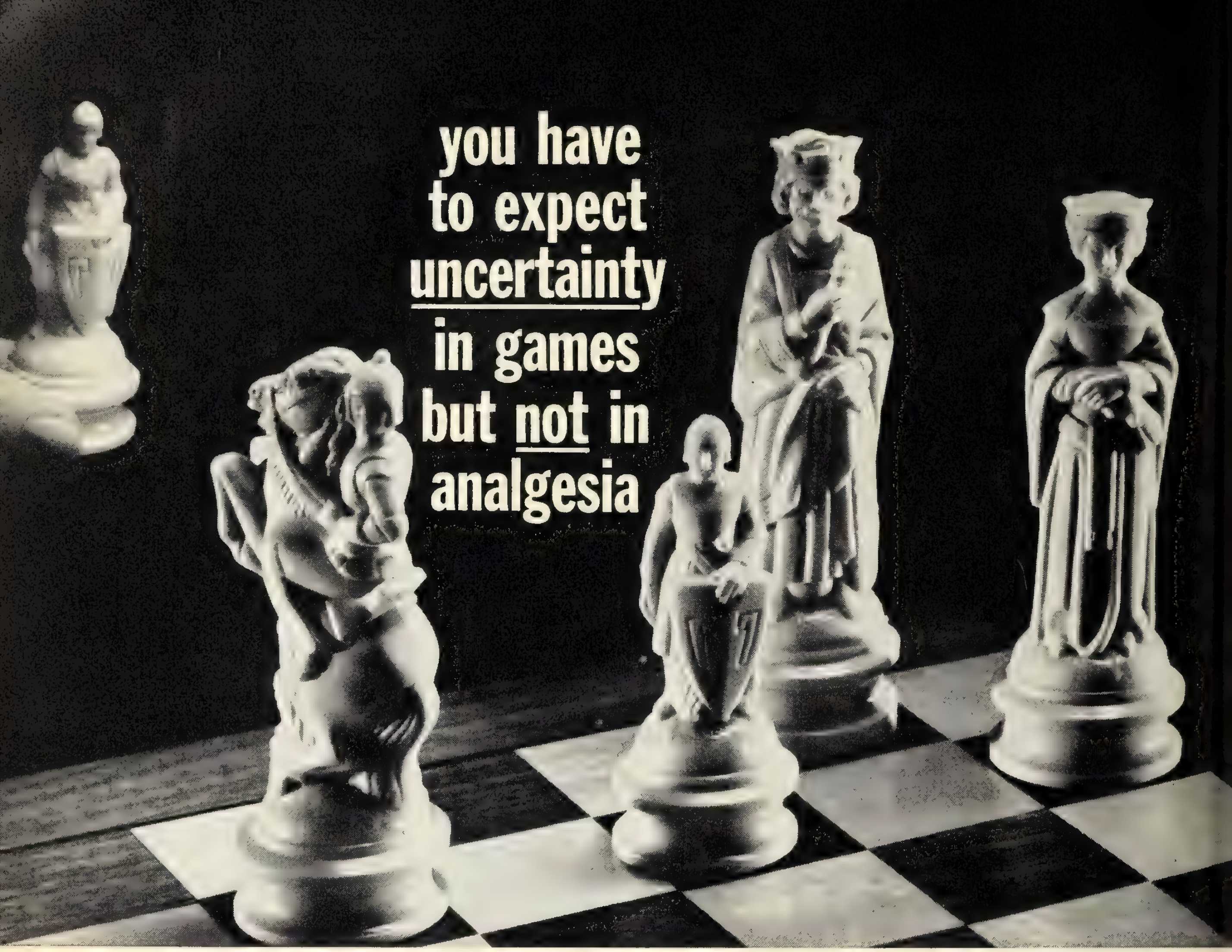

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NEWS BRIEFS

Robert O. Smith, M.D., Ionia, is a member of the board of education at Ionia, now serving in his 10th year.

Two Michigan physicians were elected to offices of leadership at the recent annual meeting of the Flying Physicians Association in Miami Beach. **David C. Boyce, M.D.**, Grand Rapids, is now a vice president, and **William C. VanGelder, M.D.**, Muskegon, is a member of the board of directors.

Wolf W. Zuelzer, M.D., Detroit, received the Emily Cooley Award from the American Association of Blood Banks recently in Miami Beach. He was cited for his contributions to research in blood diseases.

Kenneth P. Mathews, M.D., Ann Arbor, is a new member of the National Medical Advisory Committee for the Medic Alert Foundation.

Robert C. Korn, Jr., M.D., Detroit, recently received a distinguished alumni award at ceremonies marking the 50th anniversary of the Geisinger Medical Center, Danville, Pa.

A name change has been approved by the members of the Sister Elizabeth Kenny Foundation to "The Kenny-Michigan Rehabilitation Foundation." "We wanted a name which made it clear that the Kenny Foundation is a state-wide organization, serving all of Michigan with a total rehabilitation program," said **J. P. Schaupner**, president. The Foundation is an agency of the Michigan United Fund and the United Foundation.

The new president of the Michigan Health Officers Association is **Frank J. Condon, M.D.**, deputy director of the Oakland County Health Department since 1953.

Meyer O. Cantor, M.D., Huntington Woods, is the new editor of the Journal of Abdominal Surgery, which maintains its headquarters at Melrose, Massachusetts.

The new east wing of the Ingham Medical Hospital has been named in honor of **Arthur L. Stanley, M.D.**, the hospital medical director since 1960. The recent hospital ceremony honored the thoracic surgeon for his 22 years of service to the hospital.

The American College of Obstetricians and Gynecologists conducted its basic science session and annual meeting of District 5 recently in Cleveland. Speakers at the Annual Meeting included **H. Eugene Dennison, M.D.**, and **Herman C. Eldersveld, M.D.**, both of Grand Rapids; **George E. LaCroix, M.D.**, **Y. P. Bashai, M.D.**, **Joan C. Stryker, M.D.**, **Charles R. Boyce, M.D.**, **Lee B. Stevenson**, all of Detroit; and **Herman Ziel, M.D.**, Lansing, and **William Ledger, M.D.**, Ann Arbor. **Tommy N. Evans, M.D.**, Detroit, is vice-chairman of the District, and **Charles E. Darling, M.D.**, Detroit, is the Michigan chairman.

In connection with the meeting, the Conference on Obstetric, Gynecologic and Neonatal Nursing featured the following Michigan speakers: **Bernard Mendalbaum, M.D.**, **Lee B. Stevenson, M.D.**, **Eli J. Inga, M.D.**, **E. J. Turner, M.D.**, **Kamran S. Maghissi, M.D.**, **R. W. Talley, M.D.**, all of Detroit; **John R. Ottaway, M.D.**, Grosse Pointe, and **Vernon V. Bass, M.D.**, Saginaw.

One of the papers at the convention of the American Roentgen Ray Society in Washington, D. C., was by Drs. **Walter M. Whitehouse**, **Lawrence R. Griewski**, **Bruce A. Work**, **Robert Jaffe**, and **Colin Campbell**, all of Ann Arbor. The topic was "Television Fluoroscopic Control of Intrafetal Transfusion with Television Tape and Kinescopic Recordings."

MEDISCENE

Nov. 7-13—Community Health Week, throughout Michigan.

Nov. 10-11—Symposium on Reproductive Physiology, Harper Hospital Medical Center, Detroit.

Nov. 14—Michigan State Medical Assistants Society, County Officers and Committee Chairmen Conference, Kalamazoo.

Dec. 2—Saginaw Academy of General Practice—Vascular Clinic Day, Bancroft Hotel, Saginaw.

Dec. 15-17—"New Frontiers in Health," Michigan Department of Health, Division of Adult Health, Inn American, East Lansing.

Jan. 21-22—Symposium on Blood—Fourteenth Annual—Wayne State University, McGregor Memorial Conference Center (International Symposium on the Physiology of Hemostasis and Thrombosis on Jan. 21; Scientific Session on Blood on Jan. 22).

Apr. 24—Michigan State Medical Assistants Society—9th Annual Educational Seminar, Bay City.

May 2-7, 1966—Muskegon County Health Fair.

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Contraindications: Do not apply to skin which is affected by prickly heat, sunburn, depilatory application, or is otherwise irritated. Do not use near eyes or open cuts.

Precautions: Before initiating treatment, sensitivity tests should be made, as follows: Apply cream to an area about the size of a quarter on inside of upper arm and rub in well. Allow to remain for 24 hours. If no redness or itching develops, proceed with the treatment. Do not expose treated area to sunlight for extended periods.

Supplied: ½ oz. tube.

References: 1. Spencer, Malcolm C. and Becker, S. W., Jr.: **A Hydroquinone Effect,** Clinical Medicine 70:6 (June) 1963. 2. Spencer, Malcolm C: **Hydroquinone Bleaching,** AMA Archives of Dermatology 84:131 (July) 1961.

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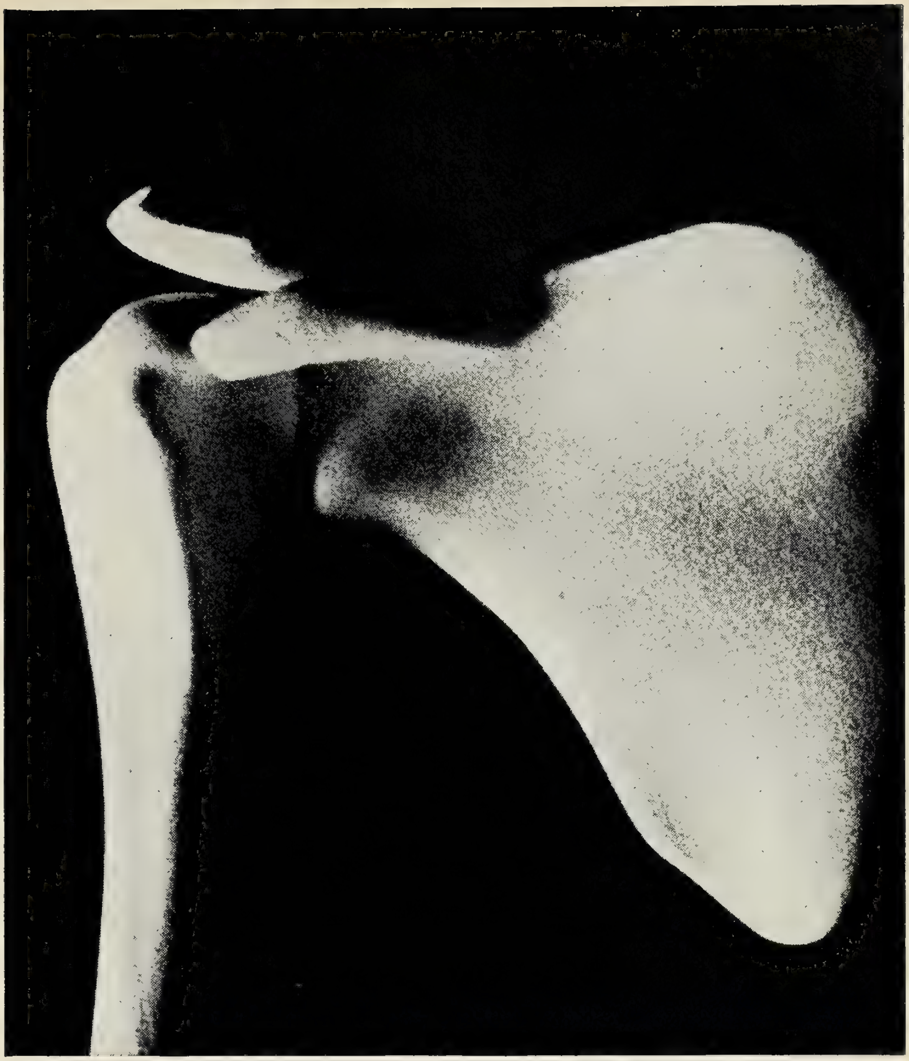

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The acute phase of subdeltoid bursitis, tendinitis and associated periarticular inflammation usually responds promptly and dramatically to phenylbutazone. Pain and tenderness may be relieved within 24-48 hours and mobility of the affected arm quickly restored. Full recovery is frequently achieved within 7-10 days so that therapy is generally of short duration. Calcific deposits are not specifically affected by treatment, but their presence does not appear to retard symptomatic improvement.

Phenylbutazone has not replaced physiotherapy, x-ray treatment, or local injections of hydrocortisone in the more chronic conditions, but it may advantageously be combined with these measures.

Contraindications

Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions

Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions

The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage

Initially, give 400 mg. daily (one capsule q.i.d), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. Butazolidin alka contains antacids and an antispasmodic to minimize gastric upset.

Note: The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

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IN MEMORIAM

CHESTER H. ADAMS, M.D.

Chester H. Adams, M.D., 61, Grand Blanc physician, died September 7 in London, England.

Doctor Adams received his medical degree from the University of Michigan Medical School in 1927 and began practice in Grand Blanc. He later moved his office to Flint and limited his practice to rheumatic disease.

From 1948 to 1950 Doctor Adams held a research fellowship in rheumatology at Cornell University Medical School in New York City. Doctor Adams was elected president of the Michigan Rheumatism Association at its annual meeting in April.

During World War II Doctor Adams served with the Army Medical Corps.

ABRAHAM BLOCH, M.D.

Abraham Bloch, M.D., 70, physician and surgeon in Detroit and a former physician for the Detroit Police Department, died September 28 of injuries suffered in a traffic accident.

A native of New York City, Doctor Bloch practiced medicine in Detroit for 43 years after graduating from Wayne State University School of Medicine in 1922. He was a founder of North Detroit General Hospital and was a staff member there and at Grace Hospital. He was physician for the Fraternal Order of Eagles and the Independent Order of Foresters.

Doctor Bloch was an Honorary Life Member of the Detroit Police Sergeants and Lieutenants Association, a member of the Jewish War Veterans, and a Life Member of the Michigan State Medical Society.

GLENN C. BOND, M.D.

Glenn C. Bond, M.D., 58, director of control at the Upjohn Company since June of 1960, died August 26 at Borgess Hospital in Kalamazoo.

Doctor Bond received his medical degree from the University of Chicago in 1941 and a Ph.D. in bacteriology from the University of Kansas.

Active in community affairs for many years, he joined Upjohn in 1942. Doctor Bond had been chairman of the Kalamazoo Citizens' Committee on Public Schools, president of the Kalamazoo County Cancer Society and a board member of the Michigan State Cancer Society.

Doctor Bond helped organize and served as the first president of the Kalamazoo Health Council and was a member of the Ferris State College Board of Control.

Doctor Bond was an Associate Member of the Michigan State Medical Society.

GROVER C. CHOSTNER, M.D.

Grover C. Chostner, M.D., 76, retired Detroit physician, died September 30 at his home in St. Petersburg, Florida.

In addition to his medical degree, Doctor Chostner held degrees in pharmacy, chemistry and education. Born in Marble Hill, Missouri, he studied at Will Masefield College there, and attended the University of Michigan, Valparaiso, Louisville, Chicago and Tulane Universities.

Doctor Chostner practiced medicine in Detroit for 25 years, and was a retired member of the Michigan State Medical Society.

CHARLES J. CLARK, M.D.

Charles J. Clark, M.D., 60, Howell, died September 21 at his home.

Doctor Clark joined the Ford Motor Company staff 30 years ago. Prior to that time he practiced medicine in Fowlerville for three years.

WAYNE W. GLAS, M.D.

Wayne W. Glas, M.D., 43, director of surgery at Wayne County General Hospital, died October 2 of a gunshot wound. His assailant is being held.

Doctor Glas was graduated from the University of Michigan Medical School and served his internship and residency at the University Hospital. Immediately following, he joined the staff of Wayne County General Hospital, later to become director of surgery there.

The author of several published papers on surgical techniques and surgical disease studies, Doctor Glas was a fellow of the American College of Surgeons. He participated in several open-heart opera-

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tions and was an expert in traumatic surgery.

Active in medical affairs, Doctor Glas served as Chairman of the Scientific Exhibit Committee for the Centennial Session of the Michigan State Medical Society.

In 1961, Doctor Glas was honored by his former interns and residents.

Doctor Glas served on the front-line in Korea in 1951 and 1952 as an Army Captain in the Mobile Army Surgical Hospital.

EDWARD HENEVELD, M.D.

Edward Heneveld, M.D., 51, Past President of the Muskegon County Medical Society, died October 9 when his private plane crashed on Beaver Island. His wife was also a victim.

A graduate of Rush Medical College, Chicago, Doctor Heneveld served his internship at Harper Hospital and Cottage Hospital in Detroit and had his first practice in Grosse Pointe. He was a general practitioner.

During World War II, Doctor Heneveld served as a battlefield surgeon.

In 1964 he took a tour on the Project Hope ship and had been active in Western Michigan in fund-raising efforts for the internationally famed mercy vessel.

Doctor Heneveld was head of the Muskegon Alcoholism Information Council in 1963.

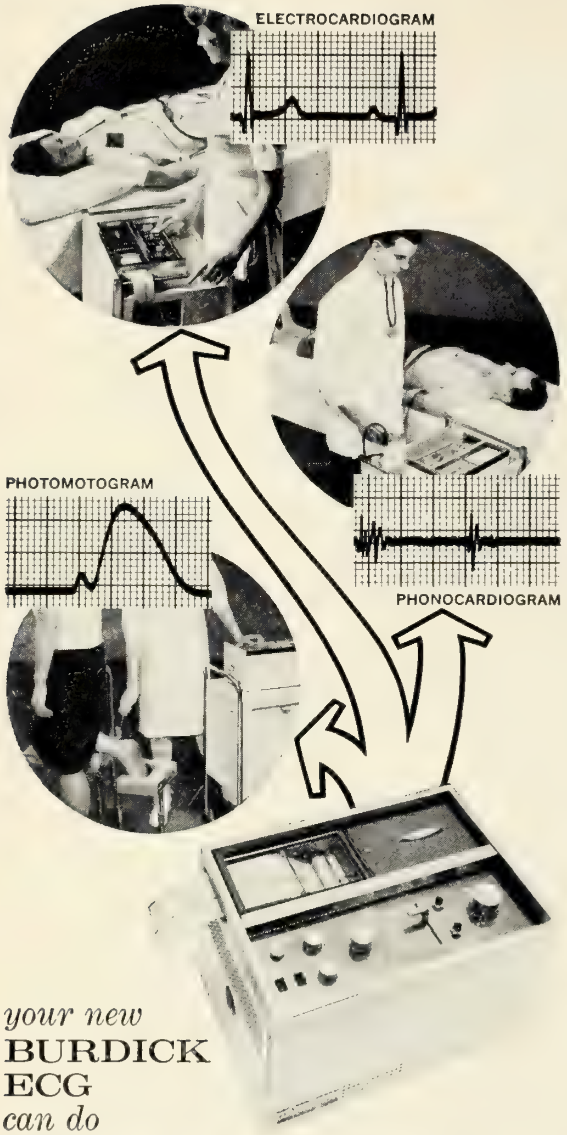
SIMON K. LEVIN, M.D.

Simon K. Levin, M.D., 88, pioneer physician and surgeon of the Upper Peninsula, died August 20 in St. Joseph's Hospital, Hancock, as the result of a fall at his home.

Born in Wensburg, Sweden, Doctor Levin moved to Michigan when a child. Doctor Levin was graduated from the University of Michigan School of Medicine in 1901, and that same year moved to Calumet where he interned at the Calumet and Hecla Mining Company Hospital. His hospital affiliations included St. Joseph's Medical Center, Hancock.

A past president of the Houghton-Keweenaw-Baraga County Medical Society, Doctor Levin also served as its vice president and secretary and treasurer. Doctor Levin was a fellow of the American College of Surgeons, a member of the Emeritus Club of the University of Michigan and served on the Goiter Committee of the National Research Bureau at Washington, D. C., for three years.

Doctor Levin was a Life Member of the Michigan State Medical Society, and in 1951 received the MSMS 50-Year Award.



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GREGORY P. MOORE, M.D.

Gregory P. Moore, M.D., 61, chief of staff at Mercy Hospital, Cadillac, died September 24 at that hospital.

Born in Monmouth, Illinois, Doctor Moore was a graduate of Northwestern Medical School. He went to Cadillac in 1932 after a two-year internship in Chicago.

Doctor Moore was a Past President of the Wexford-Missaukee County Medical Society. He was named chief of staff at Mercy Hospital in 1964.

A veteran of 39 years in the Army and the Michigan National Guard, Doctor Moore was awarded a Bronze Star in World War II when he was surgeon with the 79th Division in Europe. Doctor Moore was surgeon for the 46th Division of the Michigan National Guard after the war until his retirement as a colonel in 1961.

JOHN W. NAGLE, M.D.

John W. Nagle, M.D., 72, Wyandotte internist and heart specialist for 40 years, died September 6 at Wyandotte General Hospital where he was a member of the staff.

Doctor Nagle, a resident of Grosse Ille, was graduated from the University of Michigan School of Medicine in 1922 and interned and took his residency at Henry Ford Hospital. He came to Wyandotte in 1925 as a general practitioner and later confined his practice to internal medicine and cardiology. He was former president of the medical staff of Wyandotte General Hospital.

During World War I Doctor Nagle served as a hospital corpsmán and as lieutenant commander in the U. S. Naval Reserves during World War II.

Doctor Nagle was a Life Member of the Michigan State Medical Society and the Wayne County Medical Society.

R. H. PROUD, M.D.

R. H. Proud, M.D., 69, physician and surgeon in Flat Rock for more than 40 years, died September 22.

Born in Desboro, Ontario, Doctor Proud received his medical degree from the University of Toronto in 1924 and served his internship at Ford Hospital, Detroit. Doctor Proud opened his Flat Rock office in 1925.

Doctor Proud was former chief of staff of Wyandotte General Hospital and Seaway Hospital, Trenton, a past president of the Downriver Medical Association and an associate member of the Royal College of Surgeons.

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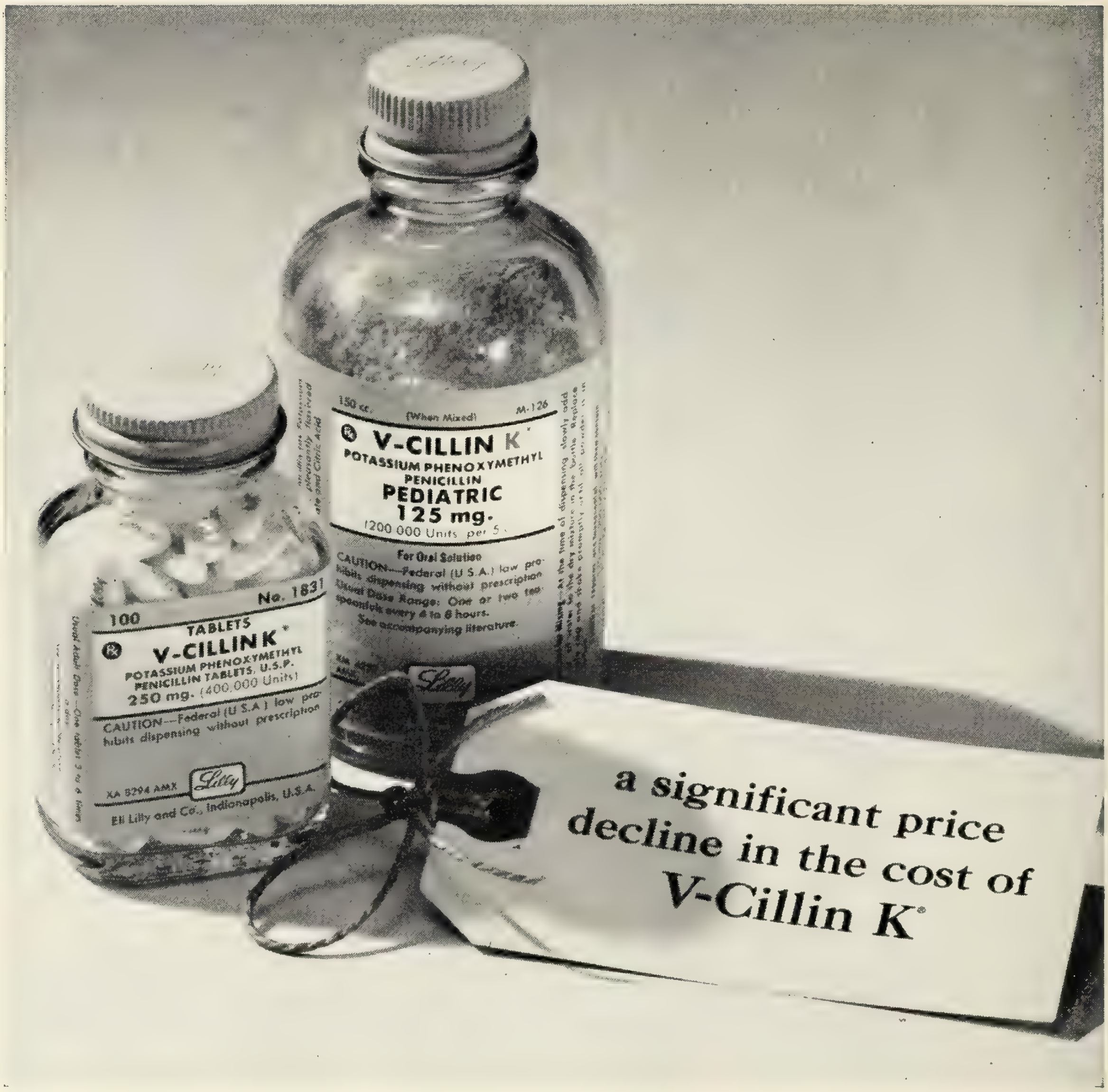
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SCIENTIFIC PAPERS

Clinical Applications of Lung Scanning

By
HOWARD J. DWORKIN, M.D.
RAPHAEL J. LESSARD, B.A.
WILLIAM H. BEIERWALTES, M.D.
ALL OF ANN ARBOR

Radioisotope lung scanning has been shown to be a reliable method for demonstrating relative pulmonary blood flow.[1-6] Pathological correlations of lung scans have been reported only sparsely[7-10] with most of the information available relating to pulmonary emboli. In order to fully comprehend the scan abnormalities seen with pulmonary emboli, scans associated with other pulmonary diseases must be studied and correlated with tissue specimens and conventional pulmonary function studies.

It is the purpose of this paper to review our first 40 lung scans in patients with a number of different pulmonary diseases and to correlate the lung scans with angiography, pulmonary function studies and tissue specimens.

METHODS

Radiopharmaceutical

^{131}I tagged macroaggregated albumin (MAA)* was used with a representative particle size distribution as presented in Table I and Figure 1. The scanning dose was 300 μc ^{131}I. Because of radioactive iodine decay the albumin dosage varied from 0.003 mg/kg to 0.19 mg/kg (mean 0.018 mg/kg).

Lung Scan Technique

The MAA was injected into the antecubital vein with the patient in the supine position. The scan was begun immediately after the administration of the MAA. The scan was started just below the xiphoid process in a cephalad direction if no sig-

TABLE I.
MAA Particle Size Distribution.

Diameter, microns	Percent ± S.D.
<5	47.7 ± 14.5
5–10	21.5 ± 7.4
10–20	16.2 ± 5.6
20–30	6.6 ± 4.0
30–40	2.8 ± 1.7
40–50	2.6 ± 2.3
50–70	1.2 ± 1.1
70–100	1.0 ± 2.0
>100	0.3 ± 0.5

Number of batches—11
Total number of particles sized—999

Figure 1. Macroaggregated albumin. The nebulous nature of the particles should be noted emphasizing the difficulty in precise sizing. The grid lines are 50 microns apart.

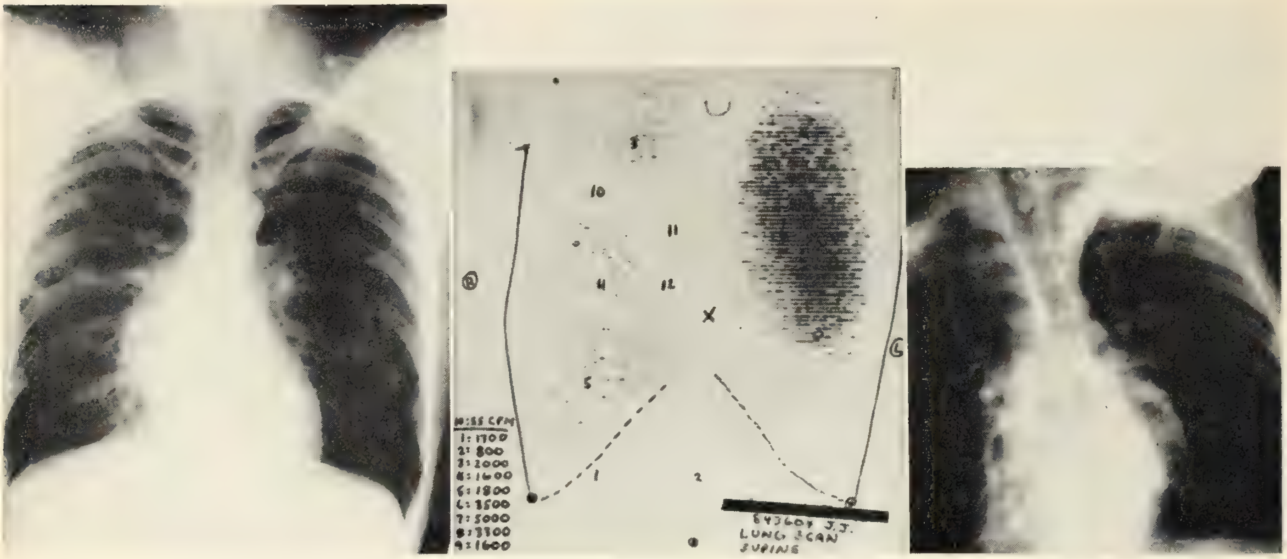
---

*MAA kindly supplied by E. R. Squibb & Sons, Cleveland, Ohio, and Nuclear Consultants Corporation, St. Louis, Missouri.

From the Department of Internal Medicine (Nuclear Medicine Unit), School of Medicine, University of Michigan, Ann Arbor, Michigan. Howard J. Dworkin, M.D., Instructor in Internal Medicine; Raphael J. Lessard, B.A., Technical Assistant; William H. Beierwaltes, M.D., Professor of Internal Medicine, Director, Nuclear Medicine.

This work was supported by the National Institutes of Health Grant HE-08069-02.

Presented in part at the Michigan Thoracic Society Meeting, University of Michigan, April 8, 1965.



a. b. c.

Figure 2. Patient J.J. (a) Chest roentgenogram, (b) lung scan, and (c) venous pulmonary angiogram. The bony landmarks routinely indicated on scans are in the midline, the suprasternal notch and the tip of the xiphoid. The lower rib margin and body contour are indicated.

nificant activity (above midabdominal aorta background) could be found on hand scanning over the liver and spleen areas. Otherwise the scan was begun at the lateral lower rib margin to include all area of increased activity. A photoscanner* was used with a 3 x 2 inch NaI (T1) crystal, a 19-hole lead collimator, a spectrometer and contrast enhancement. The usual scanning time was about one hour and the supine position was well tolerated.

Pulmonary Function Studies

The pulmonary function studies recorded were performed in the pulmonary function laboratory of University Hospital. Vital capacity (V.C.) measurements were made on a nine liter respirometer and the maximum voluntary ventilation (M.V.V.) measurements were made with a Hans Rudolph high velocity valve and neoprene gas collecting bag. Both determinations were made in the usual manner and the standards of Baldwin, Cournand, and Richards were utilized.[11] Flow rates were performed on a wedge spirometer with the output signal recorded on an electronic recorder. The standards of Danzig and Comroe[12] and Leuallen and Fowler[13] were used for these functions. Pulmonary diffusing capacity measurements were made by the modified rebreathing technique of Lewis.[14] Blood gas measurements were made with a glass pH electrode, a Severinghaus type CO_2 electrode, and a Clark type O_2 electrode. End expired air was analyzed simultaneously for its CO_2 content using an infrared gas analyzer and the technique of Robin[15,16] was used to evaluate the presence of ventilation without perfusion.

PATIENT STUDY

The patients presented below were selected because of the instructive value of the individual cases.

J. J., 39-year-old negro male, was admitted to the University Hospital in April, 1964, with a history of right chest discomfort, dysphagia and a 15-pound weight loss. Sputum cytology was positive for malignant cells and on bronchoscopy biopsy of the right bronchus was positive for malignancy. Scalene node biopsy and an upper gastrointestinal series (x-rays) were negative. Laminograms demonstrated a 13 cm diameter mass posterior to the right hilum. Radiation therapy was given prior to surgery. A venous angiogram (6/22/64) indicated mild dimunition in the caliber of the major right pulmonary arteries (Figure 2c). On 6/24/64 a lung scan was performed (Figure 2b) and demonstrated markedly diminished blood flow to the entire right lung. On 6/26/64 a right radical pneumonectomy was carried out and esophageal invasion was found. The patient expired on 6/28/64. On pathological examination the major right hilar vessels were seen to course through the tumor mass, thereby undergoing external compression. In the right lower lobe, posteriorly, a 10 x 5.5 cm tumor was found which microscopically was a poorly differentiated bronchogenic adenocarcinoma. No emboli were found.

R. G., 53-year-old white male, was apparently

---

*Picker Magnascanner, Picker X-Ray Corporation, Detroit, Michigan.

TABLE II.
Pulmonary Function Studies.

Patient	Vital Capacity, ml		Total Lung Capacity, ml	Residual Volume/ Total Capacity		Maximum Breathing Capacity, L/Min		P_aCO_2*, mm Hg	CO_2 Gradient P_aCO_2-P_ACO_2*, mm Hg		Diffusion Capacity ml/Min/mm Hg		P_aO_2*, mm Hg	P_aO_2*, mm Hg With 100% O_2
	Predicted	Measured		Predicted	Measured	Predicted	Measured		Normal	Measured	Normal	Measured		
J.J.	4175	3065		0.35		114	105.4		6					
C.O.				0.35				38	6	11			72	
J.T.	3570	3230	6804	0.35	0.53	94	91.4	33.5	6	10.5	29.0	17.5	58.5	510
J.M.	2890	1615	3340	0.35	0.52	100	42.5	59	6	9	26.1	13.0	50	430
J.C.	4330	2510	9280	0.35	0.73	121	26.1		6		31.9	12.4		
D.M.	3530	1960	5450	0.35	0.64	84	21.9	41	6	0			87	

*P_a—Gas partial pressure arterial blood.
P_A—Gas alveolar pressure.

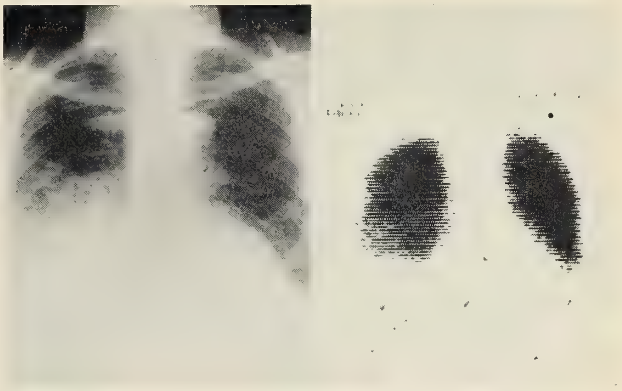
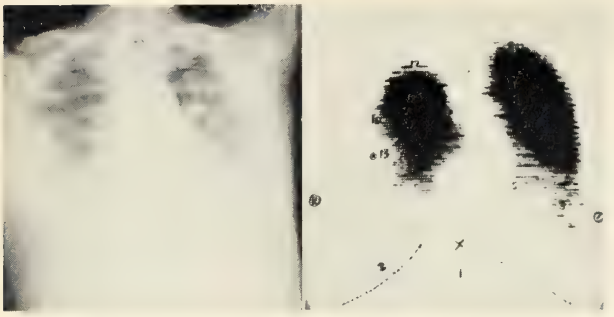

a. b.

Figure 3. Patient R.G. (a) Chest roentgenogram and (b) lung scan.

well until one week prior to admission when he developed a flu-like syndrome and was found to have a pancytopenia and a right lower lobe pneumonitis. On admission to University Hospital his vital signs were B.P. 170/90, pulse 78, respirations 28, temperature 100.4°F. He was found to have ascites and hepatosplenomegaly. Bone marrow aspirations showed hypocellularity with an abundance of malignant reticulum cells. The chest x-rays demonstrated mild cardiomegaly and a right lower lobe pneumonitis (Figure 3a). On lung scan there was evidence of diminished blood flow to the right lower lung (Figure 3b). Postmortem examination confirmed the bone marrow findings and showed a consolidation of the right lower lobe. No emboli or pulmonary artery obstruction could be demonstrated.

C.O., 45-year-old white male, had chronic glomerulonephritis with hypertension and albuminuria. He also complained of chest pain on exertion and had been diagnosed as having arteriosclerotic heart disease. In August, 1964, he experienced an episode of sudden and unusual chest pain. Shortly thereafter a series of x-rays demonstrated a density in the right middle lobe compatible with a pulmonary infarct which underwent resolution. He was started on anticoagulants. In October, 1964, the patient developed phlebitis in the right lower extremity with some increased dyspnea on exertion. He was admitted to the hospital. The blood pressure, pulse and temperature were normal with respirations 35 per minute at rest. Cardiopulmonary examination was unremarkable; however, hepatomegaly and ankle edema were noted. The serum glutamic oxaloacetic transaminase was normal. At the time of admission in October, 1964, a small density could still be seen in the posterior division of the right lower lobe. Pulmonary function studies are listed in Table II. The CO_2 gradient suggested the presence of pulmonary emboli. A lung scan performed on 11/10/64 exhibited decreased blood



a. b.

Figure 4. Patient C.O. (a) Chest roentgenogram and (b) lung scan. A crescent-shaped defect, as is seen at the periphery of the right base, is frequently seen with a pulmonary embolus.

flow to the right lower lung (Figure 4b) compatible with an embolus. The patient expired on 11/12/64 after an episode of sudden chest pain. On pathological examination a thrombo-embolus was found occluding a major arterial tributary leading to the right lower lobe.

J.T., 63-year-old white male, developed deep thrombophlebitis in 1962 and a clinically diagnosed pulmonary embolus. In February, 1964, he had an episode of sudden chest pain on urination which was again diagnosed as a pulmonary embolus. Because of pain in the left lower extremity in October, 1964, the patient was admitted. It was felt that this problem would be recurrent, despite his long-term anticoagulants, and an inferior vena cava ligation was carried out. An angiogram and lung scan performed prior to operation showed close agreement (Figure 5); the major loss of blood flow being to the left lung with some decrease to smaller areas on the right. Preoperative pulmonary function studies are shown in Table II. These were interpreted as strongly suggestive of pulmonary emboli. Postoperatively the patient has done well.

J. M., 46-year-old white female, was admitted with dyspnea on exertion and ankle swelling. The patient noted the onset of dyspnea following an auto accident in September, 1963. In December, 1963, ankle edema was first noted and a chest roentgenogram revealed an elevated right hemidiaphragm with some pulmonary congestion. The patient had a history of scarlet fever at age 20 years with uncertain cardiac involvement. She had been obese for years and more recently her weight was stable at 207 pounds. On examination the B.P. was 120/80, the pulse 96 and regular, and the respirations 20 per minute. At 50° from the horizontal the neck veins were distended. The left diaphragm moved poorly and the right diaphragm moved not at all and was elevated to percussion. Inspiratory moist rales were heard at the left base. P_2 was loud with a systolic regurgitant murmur, III/IV, heard in the tricuspid area. The admission chest x-ray showed persistent elevation of the right hemidiaphragm, cardiomegaly and mild bilateral densities at both bases compatible with early congestion. Chest fluoroscopy demonstrated a paralyzed right diaphragm with hyperlucency of the right lung. Since the question of pulmonary embolus to the right lung is suggested by the lucency, a lung scan was performed. The scan was compatible with the elevated diaphragm and with normal blood flow to the remainder of the right lung, making the diagnosis of an embolus of significant hemodynamic importance unlikely (Figure 6b). The arteriogram (not shown) revealed no obstruction of the major pulmonary vessels; however, the catheter could not be manipulated into the pulmonary artery and poor quality films were obtained. In the absence of pulmonary artery occlusion a congenital etiology might explain the

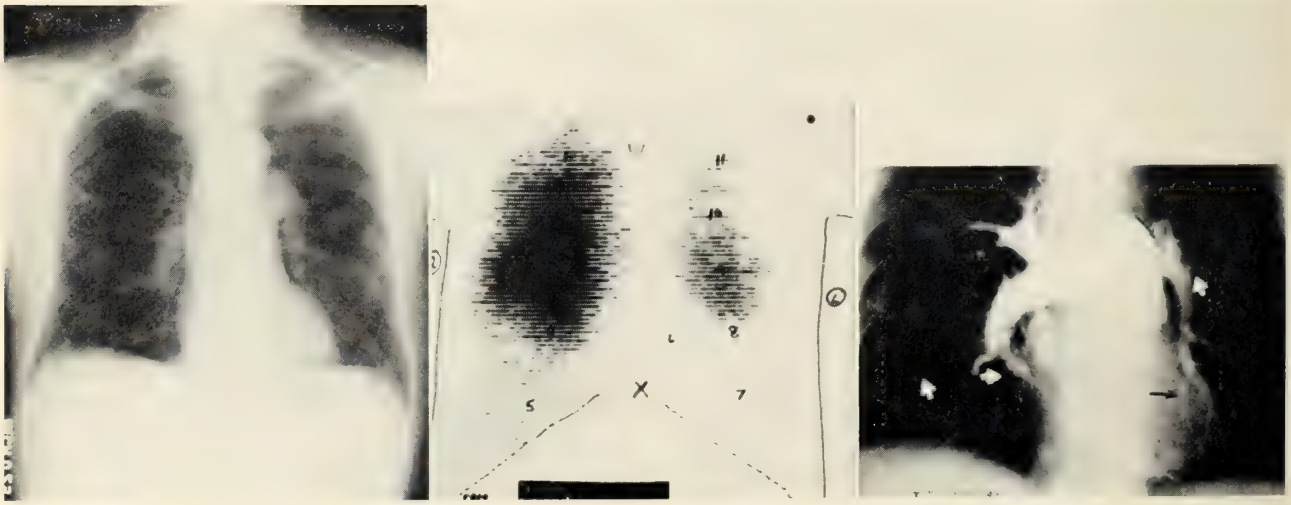


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Figure 5. Patient J.T. (a) Chest roentgenogram, (b) lung scan, and (c) pulmonary angiogram. The arrows indicate some of the areas of complete or partial obstruction.

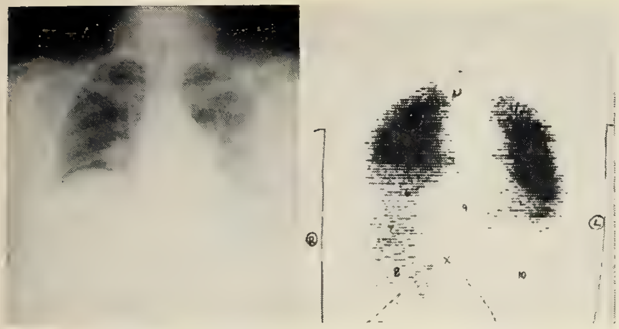
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Figure 6. Patient J.M. (a) Chest roentgenogram and (b) lung scan.

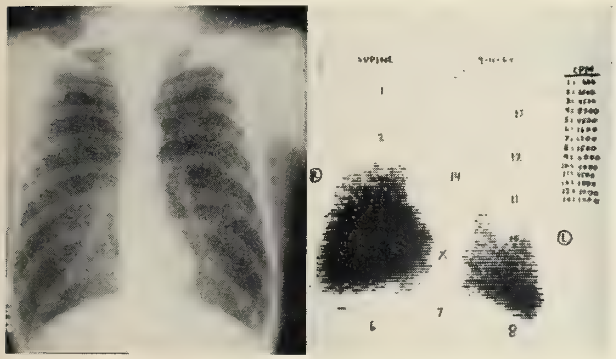
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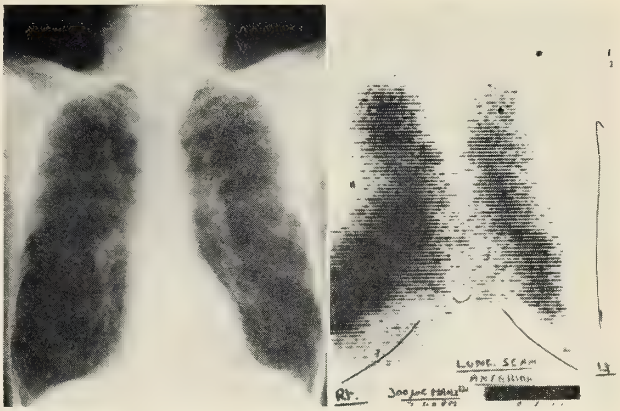
Figure 7. Patient J.C. (a) Chest roentgenogram and (b) lung scan. The numbers in the upper right corner represent point counts (per minute) over the anterior chest wall as numbered on the scan.

lucency and the right diaphragm elevation. Pulmonary function studies are shown in Table II. They show a decrease in lung volume and ventilation. The significance of the CO_2 gradient in the presence of this degree of ventilation abnormality is uncertain.

J. C., 33-year-old white male, experienced a spontaneous right pneumothorax in 1956 and in 1963 was diagnosed as having emphysema and recurrent respiratory infections. Bronchoscopy and bronchography performed in February, 1964, were consistent with the diagnosis of asthma and chronic bronchitis. There was no history of allergy. In August, 1964, the chest x-rays demonstrated bullous emphysema. Laminagrams were confirmatory and showed pronounced involvement of the upper segment of the left lower lobe. Pulmonary function studies (9/9/64) indicated an increased residual volume with a decreased expiratory flow rate and decreased diffusion capacity (Table II). These findings were interpreted as being indicative of severe airway obstruction. The lung scan (9/11/64) showed diminished blood flow to the upper half of the right lung and upper two-thirds of the left lung (Figure 7b). A significant increase in blood flow was seen lower in the chest than is normal and was compatible with flattened diaphragms and caudal displacement of the lungs by the apical blebs.



a. b.

Figure 8. Patient D.M. (a) Chest roentgenogram and (b) lung scan.

The patient is awaiting surgical resection.

D. M., 64-year-old white male, had a 10-year history of cough with intermittent production of purulent sputum, increasing shortness of breath and repeated left pneumothoraces. In 1961 he underwent a pleurodesis. There were no recent symptoms compatible with a pulmonary embolus. On examination at this time he was dyspneic at rest using accessory breathing muscles to a marked degree. His anteroposterior chest diameter was increased, with decreased breath sounds and hyperresonance. There were dry inspiratory rales at both bases. The liver extended 6 cm below the right costal margin. There was 2+ ankle edema with no clubbing. His chest x-ray was consistent with bullous emphysema (Figure 8a) and the EKG showed a right bundle branch block. The pulmonary function studies appear in Table II and are consistent with severe airway obstruction. The lung scan indicates diminished blood flow to the upper and middle lung fields as well as increased blood flow below the level of the xiphoid (Figure 8b).

DISCUSSION

Correlation with Other Tests

The acceptance of a new diagnostic test should be dependent on several factors:

(1) The test should be correlated with known pathology. The lung scan, therefore, should carefully be compared with other physiologic, x-ray and pathologic examinations.

(2) The test must offer information not attainable as easily or as safely by other existing accepted tests.

The lung scans in the seven cases described above fulfill these criteria.

Bronchogenic Carcinoma

Evaluation of the extent of invasion of lung cancer prior to surgical intervention remains a problem. Angiography has been suggested as an aid to identification of nonresectable tumors.[17] In the instance of patient J. J., new information as to the extent of blood flow diversion is made available by the scan. The more strenuous procedure of selective pulmonary angiography might have yielded similar information, but the venous angiogram gave suboptimal contrast (Figure 2c). In view of the reports of others it is worthwhile emphasizing that pathology other than massive emboli can also give a significant decrease in blood flow as demonstrated by lung scanning. Preoperative evaluation of blood flow patterns with the lung scan offers a simple method for better appreciation of the extent of intra- or extravascular spread of neoplasm.

Pneumonitis

The case of R.G. is of interest since it points out that decreased regional pulmonary blood flow can occur with infectious processes and that demonstrable vessel obstruction need not be present for this pattern to appear on the lung scan. Clinical judgment must often be used to decide if an area of diminished blood flow on the scan, coinciding with an infiltrate on the chest x-ray, represents an infarct or pneumonia. A modest decrease in blood flow as seen in Figure 3b would tend to favor an infectious process.[10]

Pulmonary Embolism

The two cases of pulmonary emboli (C.O. and J.T.) are presented to reinforce the diagnostic value of the lung scan in this condition[7] and to further indicate the close spatial correlation between the scan, angiogram and postmortem examination. The close correlation with the CO_2 gradient method should also be noted. At present the lung scan appears to have its greatest application in this area. It has been well tolerated by a number of critically ill patients and has served as a screening test for the more arduous procedure of pulmonary angiography. Our experience with lung scanning suggests that only those patients with a scan suggestive of emboli should go on to angiography and possible consideration of embolectomy. An example of the usefulness of a "negative" scan is demonstrated by J.M. The scan indicated relatively normal blood flow to the hyperlucent upper right lung. Since catheter placement difficulties can occur in pulmonary angiography[18] the scan may offer valuable supplemental information.

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Pulmonary Emphysema

Inadequate perfusion of lung in pulmonary emphysema is not an uncommon occurrence.[19,21] Patients D.M. and J.C. appear to represent part of a spectrum of increasing bleb formation and decreasing perfusion, particularly at the apices. The information offered here by the scan correlates well with x-rays and pulmonary function studies. In this instance, it appears to offer more extensive information than the laminagram (patient J.C.), for preoperative evaluation. Various degrees of focal lack of perfusion have been demonstrated by us on scanning a series of emphysematous patients. Scanning is well tolerated by these patients, even those with extreme respiratory symptoms at rest. The response of abnormal perfusion patterns to therapy may be of value for following emphysematous patients. Such follow-up has been of use in patients with pulmonary emboli.[8]

Toxicity

No clinically discernible toxicity has been noted.[8,10,22] The radiation exposure is not excessive[9] and we have observed that 85 per cent or more of the radioactivity is excreted in three days. (Patients are placed on Lugol's solution to decrease thyroid exposure.) The half-time of the activity in the lungs is about four hours (particle size dependent) and on being broken down to smaller particles the MAA passes through the lungs and is phagocytized by the reticuloendothelial cells of the liver and spleen. In these cells final degradation of the albumin particles occurs with liberation of the ^{131}I for renal excretion.

No allergic reactions to the MAA have been observed by us or others[22] clinically. Others have reported rare occurrence of low titer antibodies to human albumin in laboratory animals only on repeated use.

The third area of questionable toxicity is the hemodynamic hazard. It can be visualized that the pulmonary blood supply could be sufficiently compromised in a seriously ill patient such that plugging of just a few more capillaries (even temporarily, as is the case here) could cause a rise in pulmonary artery pressure, right heart failure, decreased left ventricular filling and decreased systemic blood pressure with consequent cerebral and myocardial ischemia. Although this clinical possibility has not been observed, the possibility cannot be ignored. An increase in the respiratory

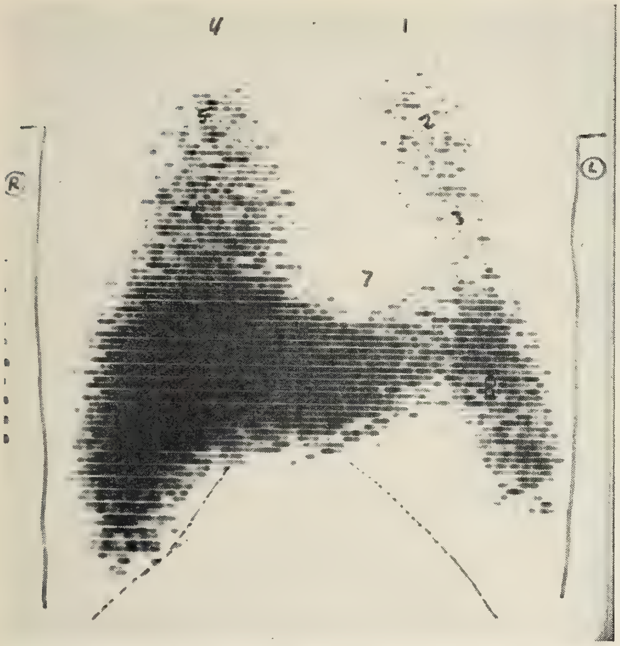

Figure 9. Lung scan of poor quality. The liver and spleen are seen plainly.

rate may be one of the earliest signs of impending hemodynamic difficulty and should be looked for while slowly injecting the MAA.[23] The "safety factors" reported in the literature of 100 to 5,000[8,22] (on a mg/kg basis) were derived from the study of animals with apparently normal vasculature. Further studies on maximum allowable dose are now in progress in our laboratory.

Present Limitations

A limitation of this technique is that small areas of decreased blood flow (below 2 or 3 cm diameter) cannot be accurately resolved with most of the currently available scanners. Thus, as is true for pulmonary angiography, small, multiple, pulmonary emboli are not well detected.

A problem that is not infrequently seen in emphysematous patients is worthy of some note. When blood flow (i.e., activity) is seen below the level of the xiphoid on scanning two possibilities are suggested:

(1) The particles may have lodged in lung tissue lying lower in the thorax than is normally seen. This would be indicative of over-distention of lung with flattened diaphragms.

(2) The MAA may be passing through the lung and depositing in the liver and spleen, which also lie at a level just below the xiphoid. The MAA particles may pass the lungs due to A-V shunts in the heart or peripherally in the lung. Another possibility is that due to an error in their preparation the preponderance of particles fall below a 5 μ size so that they are not temporarily held in the lung but are deposited, with little delay, in the liver and spleen. A marked example of such a case is shown in Figure 9. The simple technique of taking counts over a noted point of increased activity at 5, 10, 60, and 75 minutes permits an appreciation of activity gain or loss. If the observed activity falls or remains the same, one is fairly certain that the MAA particles are deposited in lung. However, if the activity rises rapidly with time, one becomes suspicious that the observed area below the xiphoid is liver or spleen. Of course, the shape of such an area on the scan may also be indicative.

SUMMARY

The MAA-^{131}I lung scan is a useful adjunct for the evaluation of relative pulmonary blood flow in patients with pulmonary emboli, pneumonitis, lung cancer and bullous emphysema. The lung scan findings are correlated with pulmonary function studies, angiography, pathology and the clinical state of the patient.

ACKNOWLEDGMENT

The authors are indebted to Josef R. Smith, M.D., for his aid in obtaining the pulmonary function studies and their interpretation and for his help in the preparation of this manuscript.

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Masked Mastoiditis

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Hippocrates wrote: "Acute pain of the ear, with continued strong fever, is to be dreaded, for there is danger that the man may become delirious and die."[1]

He was referring to the age-old problem of otitis media and its complications. The dreaded complications, particularly mastoiditis, were better known to the physicians of the pre-antibiotic era. Otitis media was a disease of greatest urgency and received maximum attention and therapy. The only effective therapy for acute suppurative otitis media before antibiotics were available was repeated myringotomies and local cleansing, until all evidence of the infection was gone.

Early surgical drainage of the mastoid was done if there was any suspicion that it was undergoing coalescence. The signs and symptoms of acute surgical mastoiditis were classical: (1) persistent purulent otorrhea, (2) pain, (3) fever, (4) mastoid tenderness, (5) swelling over the mastoid process, (6) edema and sagging of the skin of the posterosuperior aspect of the external auditory canal, and (7) systemic toxicity.

With the introduction of antibiotic therapy, mastoiditis suddenly and fortunately became conspicuously uncommon. Otitis media in almost all cases responded rapidly and completely to these drugs. Even initial myringotomy no longer seemed to many physicians to be necessary.[2] Careful follow-up examination of the ear was occasionally omitted and the course of therapy foreshortened, either because the patient or the physician became overly reassured by the early disappearance of the most disturbing symptoms, such as pain, fever, and aural discharge. Occasionally, such an inadequately treated middle ear infection continues to smoulder subclinically. It may then recur as a re-exascerbation of an acute otitis media, or extend into a mastoiditis, or it may lead to a more severe complication, such as brain abscess or facial nerve paralysis.

These complications are often difficult to recognize because the previous or reinstituted antibiotic therapy tends to suppress classical symptoms and signs. The following cases were treated at the University of Michigan Hospital during the past few years and illustrate the problem of "masked mastoiditis."

CASE #1

M.C., 10-year-old white female, admitted to University Hospitals on November 22, 1963, with c.c. of headache, dizziness and vomiting of two weeks' duration. One month prior to her hospitalization she had developed left otitis media with a bulging tympanic membrane. A combination of antibiotics had caused the pain and fever to subside, only to give way to headache, dizziness, ataxia and nausea and vomiting. Finally, one week before her hospitalization, she developed nystagmus and held her head fixed in a forward position. Any other head position made her vertigo unbearable.

Physical examination at the time of hospitalization revealed normal vital signs and temperature. She was lethargic and held her head slightly forward. She looked constantly to the right and became violently vertiginous in any other direction of gaze. She had a slow rolling-type of nystagmus to the left, on left lateral gaze. Her left tympanic membrane was slightly hyperemic and edematous, but not bulging. She had only a mild conductive hearing loss. No pus or fluid was obtained on myringotomy. She had no mastoid swelling or tenderness. She fell backward and to the right on Romberg test. She past-pointed and had dysmetria with the left hand. She also had dysdiadokokinesia on the left. There was no nuchal rigidity or papilledema. WBC was 10,100. Opening pressure on lumbar puncture was 250 mm H_2O and closing was 230 mm. CSF showed 6 WBC/cc and protein was 31 mg%. No organisms were recovered on smear and cultures of CSF. Mastoid x-rays showed diffuse clouding on the left.

Despite several days of intensive intravenous doses of erythromycin and chloromycetin, her abnormal neurological picture persisted. She was taken to the operating room on November 27, 1963, for a complete mastoidectomy. Extensive bony

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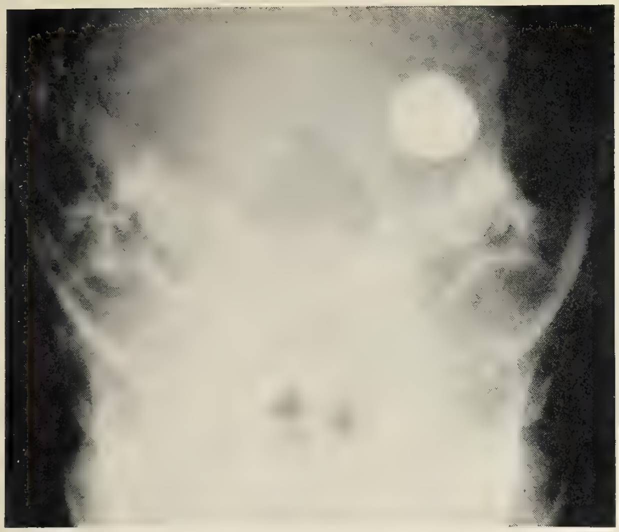

Figure 1—Case 1. Thorotrast injected into cerebellar abscess cavity through large mastoid surgical defect.

and mucosal infection was found throughout the mastoid and, in addition, the sigmoid sinus was thrombosed. Much granulation tissue was found over the tense, fluctuant cerebellar dura. This area of cerebellar fluctuance was tapped and 15 cc of pus was aspirated and the abscess cavity filled with Thorotrast for radiograph follow-up (Figure 1).

The patient showed gradual improvement postoperatively and was discharged in two weeks with virtually no residual neurological abnormalities. She has subsequently returned to school and is doing "A" and "B" work. Her hearing is normal bilaterally.

CASE #2

D.S.R., 10-year-old white female, admitted to University Hospital on October 6, 1961, with a three-month history of discharge from her left ear. This had initially subsided for several weeks on systemic and topical antibiotic therapy, but recurred and persisted until her admission to the hospital. One week before hospitalization she also developed pain in her left ear. She became anorexic and vomited on several occasions.

On physical examination, her left ear was protruding from the side of her head with redness and tenderness over the mastoid swelling. The posterior-superior external canal wall skin was edematous and sagging. A large polyp was protruding from the middle ear through a central perforation of the tympanic membrane. Temperature and vital signs were normal. WBC was 9,050, mastoid x-rays revealed cloudiness of the mastoid cells on the left.

A complete mastoidectomy was performed on the day after admission with the finding of necrotic bone throughout the mastoid. The polyp was removed from the middle ear and an adenoidectomy was performed at the end of the ear procedure. The patient was discharged in ten days after an uneventful postoperative course.

CASE #3

G.S., five-year-old white male, was admitted to University Hospital on May 5, 1964, with a complete right peripheral facial paralysis of one day's duration, which had followed by one week the onset of acute suppurative otitis media on the right. The suppurative otitis media had started with pain but no fever or otorrhea.

The patient had been treated for several days with penicillin and a sulfonamide. Gradually the pain subsided but the facial paralysis appeared. On physical examination, the patient was somewhat lethargic and had a complete peripheral-type facial paralysis on the right (Figure 2). Neurological examination was normal otherwise. The patient's temperature and vital signs were normal. Both tympanic membranes were retracted and immobile

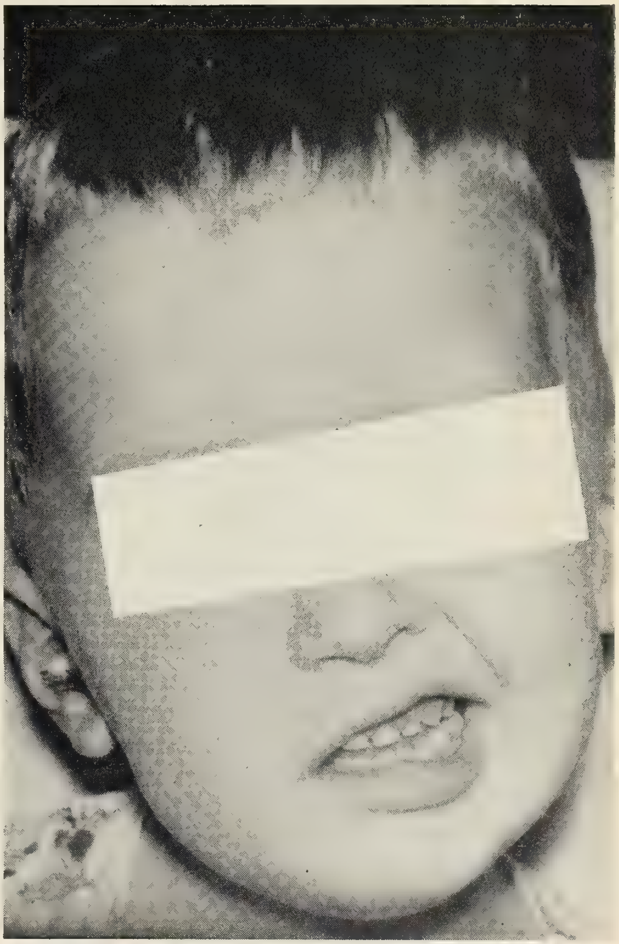

Figure 2—Case 3. Complete right peripheral facial paralysis, secondary to mastoiditis.

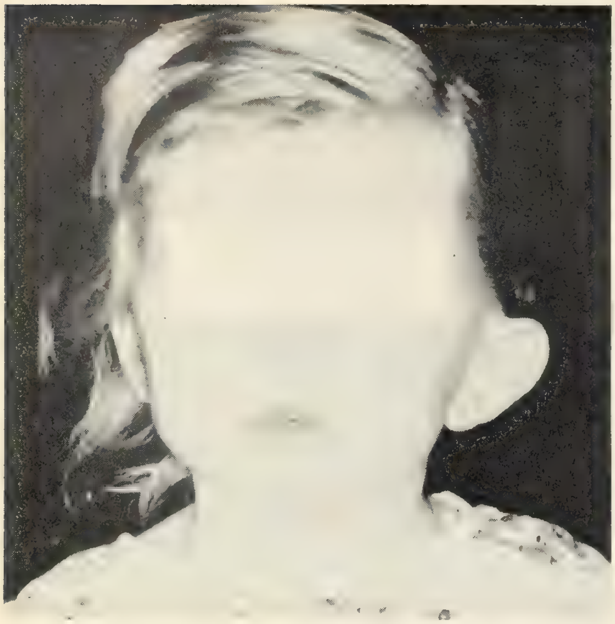

Figure 3—Case 4. Subperiosteal abscess secondary to mastoiditis.

and there was a mild conductive hearing loss bilaterally. Only a small amount of serous fluid was obtained from each middle ear upon myringotomy. There was no mastoid tenderness or swelling. WBC was 9,200. Mastoid x-rays showed slight cloudiness on the right. The facial paralysis failed to improve in the hospital on therapeutic doses of penicillin and sulfonamides, and serial EMG and percutaneous square wave electrical testing showed increasing evidence of degenerative changes in the nerve. Repeat mastoid x-rays, one week after admission, also revealed progression of the bony destructive changes on the right.

The patient was taken to surgery on May 18, 1964, and a complete mastoidectomy and facial nerve decompression were performed on the right side. The bone of the mastoid was abnormally soft, and free pus was encountered in the mastoid air cells. The communication between the mastoid antrum and middle ear was blocked by edematous mucosa. The facial nerve was edematous and expanded readily out of the constricting confines of its sheath when a neurolysis was done from the middle ear to the stylomastoid foramen.

Ten days postoperatively, the patient could again close the right eye and by three weeks had good facial tonus. By the sixth postoperative week, the right side of the face moved normally. His hearing had returned to normal bilaterally.

CASE #4

C.B., three-year-old white female, was admitted to University Hospital on February 3, 1964, with a six-week history of drainage from the left ear. This was initially accompanied by pain in the ear, but the pain gradually subsided and was replaced by progressive swelling behind the ear. When this swelling developed, the patient was placed on Pan Alba suspension every six hours for two weeks, until her hospitalization. There was no fever or malaise. On physical examination, the child was bright and alert with a prominent, fluctuant postauricular swelling (Figure 3). The ear canal was slightly edematous but the tympanic membrane was intact. She was afebrile. WBC was 14,000. Mastoid x-rays were reported as "normal."

A complete mastoidectomy was performed the day of admission. A large subperiosteal abscess was opened with the initial skin incision. The pus was cultured and yielded hemolytic streptococci, group A. The bone of the mastoid was abnormally soft and the communication between the mastoid and middle ear through the additus was completely blocked by granulation tissue.

The patient was discharged in one week and was noted to have a normal ear on postoperative follow-up.

CASE #5

D.T., three and one-half-year-old white female, was seen at University Hospital on January 31, 1965, one month following the onset of a complete peripheral facial paralysis on the left. This paralysis had occurred 36 hours following a severe febrile illness. There was no ear pain at any time and several myringotomies early in the course of the paralysis failed to release any pus or fluid from the middle ear. The patient was placed on penicillin, tetracycline and steroids, immediately after the onset of the facial paralysis. The fever subsided, but the paralysis remained unchanged in spite of therapy. Physical examination on admission to the University Hospital revealed a complete peripheral-type facial paralysis on the right. The patient was afebrile. There was no mastoid swelling or tenderness. The tympanic membranes were slightly hyperemic but otherwise normal. WBC was 9,900. Mastoid x-rays were normal with good definition of air cells bilaterally. Repeated electrical testing using square-wave percutaneous stimulation and EMG revealed complete reaction of degeneration in the VIIth nerve on the left side.

A complete mastoidectomy and facial nerve decompression were performed on February 2, 1965. Abnormally soft bone in the mastoid area and granulation tissue filling the mastoid antrum were found. There was a pathological dehiscence in the bony Fallopian canal surrounding the facial nerve in the retrofacial cells and a large mass of granulation tissue was in contact with the exposed facial nerve. The nerve was edematous in this exposed

TABLE I.
Clinical Features of "Masked Mastoiditis"

Case No.	Duration of Infection	Fever	Pain	Tympanic Membrane	WBC	Mastoid X-Ray	Complication
1	4 weeks	none	none	Intact	10,100	Abnormal	Brain abscess Sigmoid sinus Thrombosis
2	12 weeks	none	yes	Perf and Disch.	9,050	Abnormal	None
3	2 weeks	none	none	Intact	9,200	Abnormal	Facial Paralysis
4	6 weeks	none	none	Intact	14,000	Normal	None
5	4 weeks	none	none	Intact	9,900	Normal	Facial Paralysis
6	2 weeks	none	yes	Intact	7,000	Abnormal	Epidural Abscess
7	12 weeks	none	none	Intact	13,700	Abnormal	Facial Paralysis

segment and expanded readily out of the constricting nerve sheath upon neurolysis.

The postoperative course was uneventful and the patient was discharged from the hospital in seven days. Within two weeks postoperatively, she had good return of facial motion on the left side and in six weeks the facial motion was virtually normal.

CASE #6

V.G., five-year-old white female, admitted to University Hospital on January 11, 1963, with a two-week history of pain in the left ear and fever. The patient had been treated during these two weeks with a sulfonamide preparation. During this period she developed a swelling behind the ear which progressively enlarged. Physical examination confirmed this large, fluctuant, tender, soft-tissue swelling behind the left ear. Both tympanic membranes were intact and not bulging. A myringotomy on the left side did not release any pus or fluid. The patient had a mild hearing loss bilaterally. There was no fever. WBC was normal. Mastoid x-rays revealed clouding on the left side.

A complete mastoidectomy was performed with the release of a subperiosteal abscess on the initial incision. This pus was cultured and yielded coagulase negative staphylococci and group B pneumococci. The bone of the mastoid was pathologically soft and the mastoid cells were filled with granulation tissue which blocked their communication with the middle ear. An epidural abscess was found overlying the dura of the sigmoid sinus and cerebellum and this was drained and its walls curretted.

An adenoidectomy was done following the mastoidectomy. The postoperative course was uneventful and the patient discharged in one week.

CASE #7

A.B., 53-year-old white male, was admitted to University Hospital on September 3, 1963, with a three-day history of right facial nerve paresis of the peripheral-type. He had been having intermittent pain and discharge from the right ear for the previous three months. He had been carefully followed for the ear infection with multiple myringotomies, culture and sensitivity studies, and repeated courses of several different antibiotics specified by the sensitivity studies. The otorrhea finally subsided ten days prior to the onset of the facial paresis.

He had a proven diagnosis of lupus erythematosis and had been on Chloroquin and steroids with no recent clinical manifestations of this disease. Physical examination revealed an incomplete peripheral facial paralysis on the right side. The right tympanic membrane was mildly hyperemic but not bulging. He had a moderate conductive hearing loss in the right ear. There was no mastoid swelling or tenderness. Temperature was normal. There were no physical manifestations of L.E. WBC was 13,700, HB 16.3 grams, and urinalysis was normal. Mastoid x-rays showed clouding of the right mastoid with complete absence of bony cellular detail around the mastoid antrum.

After one week in the hospital with no improvement of the right facial paresis, a complete mastoidectomy was performed with decompression of the facial nerve. Much soft, osteitic mastoid bone was encountered. The mastoid air cells were filled with highly vascular pyogenic granulation tissue. The bone of the Fallopian canal surrounding the facial nerve was soft and osteomyelitic and was removed. The facial nerve was markedly inflammed and expanded out of the constricting nerve sheath after neurolysis. The postoperative course was uneventful and the patient had good return of facial function within six weeks.

DISCUSSION

Table I summarizes the masked clinical picture of acute surgical mastoiditis treated with antibiotics. In all but two of the cases, a serious complication finally led to the diagnosis and proper surgical therapy of the underlying mastoid infection.

An average of over six weeks ensued between the onset of the middle ear infection and the clinical appearance of the mastoid complication. No one typical bacterial organism was found in this series of cases.[3]

The treatment of choice of mastoiditis is the prevention of it by vigorous and sustained antibiotic therapy for the initial acute suppurative middle ear infection. Culture and sensitivity studies and appropriate alteration of antibiotics should be done when the discharge fails to subside in five to seven days. Pus under pressure in the middle ear, which causes the tympanic membrane to bulge, should always be surgically drained by myringotomy. Certainly, the treatment of every case of acute suppurative otitis media must have careful follow-up examination and clearance by the physician, so that the patient can be reasonably assured that no complications will develop.

The decision to intervene surgically in a persistent case of suppurative otitis media is a matter of clinical judgment.[4] It must include a thorough assessment of the signs and symptoms and clinical course, which must then be correlated with laboratory and x-ray findings. Surgical intervention should be seriously considered if one or a combination of the following developments appear:

(1) If the clinical picture of an acute otitis media fails to improve, or indeed worsens, after two to three weeks, despite intensive conservative therapy.

(2) If the signs and symptoms of a threatened or actual complication appear during the course of an acute otitis media.

(3) If a facial paralysis occurs during the course of an acute otitis media and progresses to reaction of degeneration, as demonstrated by percutaneous square-wave electrical testing and EMG.

(4) If there is definite x-ray evidence of mastoid bone necrosis, particularly if it can be shown to be progressing on serial x-ray studies.

SUMMARY

Seven cases of acute surgical mastoiditis have been presented which have been seen in the University Hospital during the past four years and which demonstrate the masking effect of antibiotics upon the clinical picture. With early, adequate antibiotic therapy and drainage of pus by myringotomy from the middle ear, acute suppurative otitis media should rarely go on to coalescent surgical mastoiditis. When evidence accumulates in favor of mastoiditis during a lingering acute suppurative otitis media, mastoidectomy should be performed. The risks of temporizing, in hopes of spontaneous or medical recovery, are often greater than the negligible risks of a properly timed and properly executed mastoidectomy operation.[1]

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X-RAY PELVIMETRY AND CEPHALOPELVIC DISPROPORTION

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GRAND RAPIDS

Butterworth Hospital in Grand Rapids, Michigan, is a community hospital of 467 beds. In 1963 there were 3,139 confinements. Of the total number of deliveries, 183 mothers required x-ray pelvimetry to rule out cephalopelvic disproportion. Pelivimetric studies in our hospital are performed according to the Colcher-Sussman technique. Of the 183 pelvimetry studies, 131 were done at the hospital while 52 were performed in the offices of private radiologists. The number of Cesarean sections performed for cephalopelvic disproportion was 55, two of these having no pelvimetry. Therefore, 29 per cent of all pelvimetries required Cesarean section.

Of the 53 patients requiring Cesarean section, 33 were done while the mother was in labor. Twenty mothers were not permitted a trial of labor and had elective Cesarean sections. The following two charts represent the position of the fetus and the average weight of the newborn at birth. (Charts 1 and 2.)

Our immediate observation is that the weight of the infants whose mothers were permitted a trial of labor averaged approximately one pound more than those delivered by elective Cesarean section.

The length of labor of patients having a trial of labor varied from five to 38 hours. Chart 3 shows the average length of labors with the various presentations.

Admittedly, accurate determination of length of labor is not always possible as initiation of labor is frequently not easy to assess.

Charts 4 and 5 are interesting because it will show us the various weights of the babies at the time of birth.

Chart No. 6 shows the site of pelvic contraction

CHART 1.
Number of patients not permitted trial of labor (Total 20)

Position	Number	Average weight
Cephalic	13	7# 1 oz.
Breech	6	7# 11 oz.
Face	1	6# 3 oz.

CHART 2.
Number of patients permitted trial of labor (Total 33)

Position	Number	Average weight
Cephalic	28	8# 1 oz.
Breech	4	8# 7 oz.
Brow	1	8#

CHART 3.

Presentation	Average length of labor
Cephalic	18.2 hours
Breech	8.0 hours
Brow	18.0 hours

CHART 4.
Trial of Labor

Presentation	Largest	Smallest
Cephalic	9# 5 oz.	6# 10 oz.
Breech	9# 12 oz.	7# 8 oz.

No Trial of Labor

Presentation	Largest	Smallest
Cephalic	8# 10 oz.	4# 5 oz.
Breech	9# 1 oz.	5# 3 oz.

CHART 5.

Presentation	Weight	Trial of Labor	No Trial of Labor
Cephalic	>9#	4	0
	>8#	11	4
	>7#	11	7
	>6#	2	0
	>5#	0	0
	>4#	0	2
Breech	>9#	1	1
	>8#	2	3
	>7#	1	0
	>6#	0	1
	>5#	0	1
Brow	>8#	1	0
Face	>6#	0	1

CHART 6.
Trial of Labor

Contraction site	Cephalic	Breech	Brow
Inlet	9	1	0
Mid-pelvis	18	3	1
Outlet	0	0	0

No Trial of Labor

Contraction site	Cephalic	Breech	Face
Inlet	4	1	1
Mid-pelvis	6	2	0
Outlet	3	3	0

Department of Obstetrics and Gynecology, Butterworth Hospital, Grand Rapids, Michigan.

CHART 7.
Fetal Outcome

Labor	Weight	Diagnosis	End Result
None	5# 3 oz.	Prematurity	Recovered
None	4# 5 oz.	Prematurity	Recovered
None	4# 11 oz.	Prematurity with Respiratory Distress Syndrome.	Recovered
15 hrs.	9# 12 oz.	Newborn pneumonitis	Recovered
18 hrs.	7# 15 oz.	? CNS anomaly: flaccid paralysis of arms and legs. No autopsy	Expired on day 12
38 hrs.	8# 4 oz.	Fetal Anoxia	Stillborn

that prevented or supposedly precluded vaginal delivery.

It is interesting to note that in those women permitted a trial of labor there were no Cesarean sections performed for an outlet contraction.

Of the remaining 130 patients requiring pelvimetry, but not Cesarean section, 29 or 22 per cent were reported to have one or more small measurements. Of this number, four newborns weighed greater than nine pounds at birth, three greater than eight pounds, 15 greater than seven pounds, four greater than six pounds, and three greater than five pounds.

Of course our primary purpose in obstetrical medicine is the emergence following labor or Cesarean section of a healthy mother and an equally healthy child. There were no maternal deaths or serious complications in any of the 53 mothers who underwent Cesarean section. This cannot be held true for the newborn as Chart 7 will attest.

This makes us immediately aware of the hazard of elective Cesarean section, namely, prematurity, which constituted 15 per cent of all elective Cesarean sections in this series.

The three newborns whose mothers were permitted to labor show:

1. The possibility of newborn pneumonitis in an infant, whose mother in this case had a ruptured bag of water for over 24 hours.
2. The second case was inexplicable due to lack of an autopsy.
3. An unfortunate but not unexpected result of prolonged labor (38 hours).

CONCLUSIONS

1. The reporting of small pelvic measurements by the radiologists does not in itself necessitate Cesarean section. Twenty-two per cent of this series had one or more subnormal measurements and subsequently had vaginal deliveries.
2. All expectant mothers with small or borderline pelvimetric studies should be permitted to go into labor with perhaps the exception of breech presentation. Even then, clinical evaluation of fetal size should be done to avoid deliverance of a premature newborn.
3. Fifteen per cent of all newborns delivered by elective Cesarean section in this series were premature, probably due to error in estimating fetal size or the expectant date of confinement.
4. Outlet contraction necessitating Cesarean section was not found in any of the 33 patients having a trial of labor.
5. Active labor lasting over 24 hours should be terminated, not only for the mercy of the mother, but for the welfare of the newborn.

SUMMARY

A critical analysis of x-ray pelvimetry performed on 183 patients delivered in 1963 at Butterworth Hospital, Grand Rapids, Michigan, has been presented.

SAGINAW VASCULAR DAY SET FOR DEC. 2

A group of physicians and surgeons from the University of Denver, Colorado, Medical School will present the program at the Saginaw Academy of General Practice Vascular Clinic Day, December 2.

The topic will be "Renal and Hepatic Transplants and Related Problems," reports W. C. Averill, M.D., Saginaw, chairman. Interested physicians should contact Dr. Averill, 2110 Morson, Saginaw.

Coming in December

The last issue of MICHIGAN MEDICINE for 1965 will lead off with an authoritative article on the management of the high risk obstetrical patient by Robert E. L. Nesbitt, M.D., Professor and Chairman of the Department of Obstetrics and Gynecology at the State University of New York, Upstate Medical Center.

An authoritative review of narcotic and non-narcotic analgesics that should be of interest to all physicians will be presented by T. J. DeKornfeld, M.D., of the Department of Anesthesiology at the University of Michigan. The Director of the Cardiovascular Unit at the University of Vermont, Wilhelm Raab, M.D., presents his views on the prevention of ischemic heart disease. Interesting case reports on Psoriasis Complicating Radiotherapy and other matters of interest will also be in the next issue for your interest and information.

A Narrative Report on The Tornado Disaster

IN THE
ANCHOR BAY AREA
MAY 8, 1964

By
W. B. CARRUTHERS, M.D., F.A.C.S.
DAN ZAVELA, M.D., F.A.C.S.*

On May 8, 1964, a tornado occurred in the area of Anchor Bay, Michigan. St. Joseph Hospital of Mt. Clemens played a major part in treating the injuries resulting from this tornado.

Within minutes after the warning was received by the hospital that a tornado had occurred, patients began arriving in the emergency room in vast numbers. Eighty-six patients were treated and 59 were admitted. There was very little time for any initial organization because of the sudden overloading of our emergency room facilities. Several patients were treated in each room and major injuries were transferred to the operating room where they were cared for by separate personnel.

Within minutes after the patients began arriving in the emergency room, staff personnel were advised of the disaster and responded very quickly to the sudden emergency. Approximately 30 staff physicians were in attendance during the major portion of the disaster.

Radiological facilities were utilized to capacity, in that necessary films were taken both adjacent to the emergency room in the radiology department as well as in the operating room and interpreted by the different radiologists to facilitate the treatment of the more seriously injured patients. Radiological studies were performed upon 61 patients and a total of 113 anatomical sites were x-rayed.

Minor injuries were treated in the emergency room and major problems were handled by the staff in the operating room.

SUMMARY AS TO DEPARTMENTS

EMERGENCY ROOM: There was very little time for initial organization because of the suddenness of the disaster and because of the overwhelming number of patients brought to the emergency room almost simultaneously. As many minor injuries as possible were treated in the emergency room. Major problems were sent to the operating room where separate facilities were available for the treatment of same.

From our experience encountered in the emergency room, it was felt that an identification tag should be placed on each patient as he entered the emergency room. The tag should bear a number, be constructed of a water-proof material and should bear the name of the physician assigned to care for this patient. After initial assessment of the patient as to the type of injury, the necessary radiographs could be ordered. This could be in the form of a slip listing the anatomical sites and all that would be required would be a mark beside each site to be x-rayed. On the reverse side of this slip, the same anatomical sites could be marked and these could be checked off by the technician as the films were completed. An area at the bottom of the slip could be left vacant for the radiologist's interpretation of the films. This is only a suggestion and most certainly would be modified by the radiology department to best fit its own particular needs. Once the patient had been assigned a number and physician in attendance, then registration could take place conveniently away from the emergency room and even after the patient was admitted.

If possible, an area might be vacated in one section of the hospital for the care of the emergency cases, so that they would not be scattered throughout the hospital and thus make identification records, etc., more readily obtainable.

RADIOLOGY DEPARTMENT: The radiology department appeared to be utilized to its fullest capacity. Films were taken both adjacent to the emergency room and also in the operating room. Patients requiring only the care of minor wounds could be designated to the area adjacent to the emergency room for the necessary radiographs and those requiring major surgery of any note could be transported to the operating room and the radiological studies performed as necessary. This would free the emergency room for the care of many minor wounds and would thereby lessen the load

Co-author
W. B. CARRUTHERS, M.D.

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in the emergency room at any one given period.

OPERATING ROOM: The operating room appeared to function very well and as many as two patients were treated simultaneously in the same room. This, of course, becomes a necessity when the load is as great as the disaster of May 8, 1964. The response of the staff was very dramatic and all operating rooms appeared to be utilized to their fullest capacity. Approximately 30 patients were treated in the operating room (two of whom required craniotomies). Multiple fractures were treated by the orthopedic staff and multiple extensive lacerations were treated by the staff physicians in attendance. Two cases of gas gangrene occurred following the tornado disaster; clostridium perfringens was isolated in these two cases. These cases were treated by extensive debridement, anti-gas gangrene serum, antibiotics and secondary closure of the involved wounds by skin graft when the infection had completely subsided.

A more detailed report of the morbidity should be considered as an addendum to this report.

One would like to suggest that a doctor be assigned to each of the rooms in the emergency room. He should be responsible for the patients who enter his particular room and should make the decision as to whether the patient should be treated in the emergency room or proceed to the operating room. It is very difficult for one person to be a coordinator and also try to perform minor surgery at the same time.

The assignment of patient numbers for identification purposes could be done as the patients leave the ambulance or as they enter the emergency room. To facilitate the treatment of the patients, the doctor in charge of the particular room in the emergency room could give orders to someone in attendance at the time of the examination of the patient. This would leave the attending physician free to perform emergency treatment such as application of dressings to open fractures, large gaping wounds, etc. Also he would not be involved in any actual writing at the time of the initial treatment of the patient. If enough personnel were available at the time of any future disaster, two registrars could be assigned to each room in the emergency room for this purpose.

One of our major problems was not knowing which physician treated which patient. This is of very major importance as some patients had no doctor in attendance after admission. This situation however was quickly corrected the day after the emergency.

To assist in caring for the victims of a tornado or any other disaster, key personnel in each department might be notified and it should be their responsibility to notify other members of their departments. This would leave the switchboard free for other urgent calls.

We found in general that the response to the various departments was accomplished hastily but that the initial organization left room for some improvement.

Continual Learning

(Following are excerpts from an editorial by W. E. Brown, D.D.S., Editor, Journal of the Michigan State Medical Association, Volume 47, No. 7.)

One of the distinguishing features of a professional person is that he is a continual student—or at least he should be.

The profession is doing much to make postgraduate education more readily available.

Moreover, regular society meetings and improving journals provide educational opportunities that are readily accessible. All one has to do is participate and read.

The professional man should not limit his learning to those subjects that pertain directly to his scientific endeavors. He should broaden his horizons so that he can participate in, or at least appreciate, the world in which he lives. The study of good literature, music, art politics, philosophy, and sociology will make him a more interested and a more interesting person and likely more competent as a health professional.

What can be done to help the person who has no desire for continuing his learning?

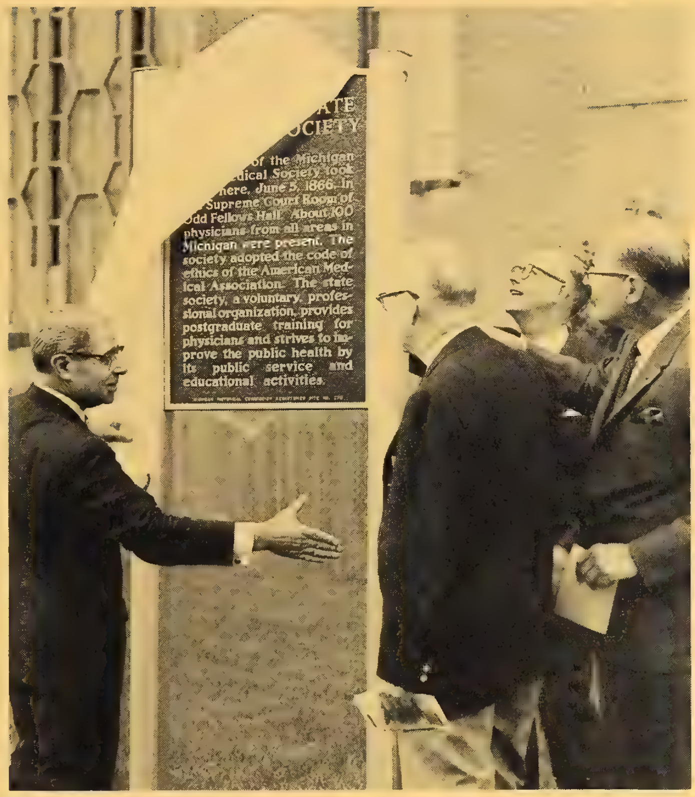
Although, in a sense, everyone continues to learn as long as he is alive, real learning requires effort. It has been suggested by some that periodic re-examinations or evidence of participation in short courses are required by state boards of dental examiners for maintenance of licensure. This compulsory learning would stir up resentment. Surely voluntary participation is preferred, if it can be accomplished. Probably the solution rests with the schools in convincing their students that undergraduate education is only the beginning.

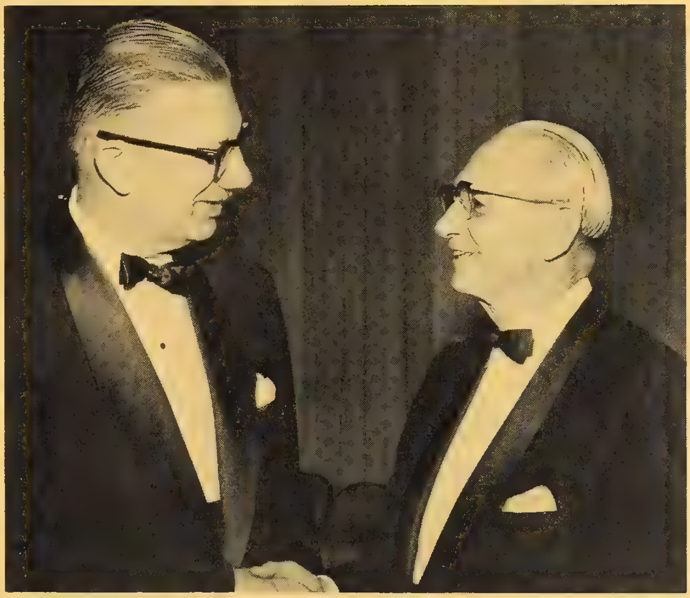
It is a joy to talk with those who have just completed a well-conducted short course. They are stimulated; they are enthused; they are challenged; they feel certain that they can provide a finer service for the patients; and they plan to come back for more. One can only feel sad for those who have not enjoyed such an experience.

A recent count shows that some 220,000 medical articles are published annually. Of these, 82,000 or 37 per cent are published in English—almost four times as many as in the runner-up, German (10%).

Cameras Capture Centennial Festivities

BELOW: It takes considerable puffing to blow out 100 candles on the healthmobile-shaped birthday cake at the Medicine and Voluntary Health Day Luncheon by Doctors Leader and McGillicuddy.


ATE
OCIETY
of the Michigan
edical Society took
here, June 5, 1866. In
Supreme Court Room of
Odd Fellows Hall. About 100
physicians from all areas in
Michigan were present. The
society adopted the code of
ethics of the American Med-
ical Association. The state
society, a voluntary profes-
sional organization, provides
postgraduate training for
physicians and strives to im-
prove the public health by
its public service and
educational activities.



AT TOP: The drape is removed by Charles E. Feinberg, left, President of the Michigan Historical Commission, from the official historical marker at the site of the first MSMS meeting 100 years ago in Detroit.

ABOVE: Best wishes are exchanged between C. Allen Payne, M.D., left, who is the new MSMS President-Elect, and Luther R. Leader, M.D., following his installation to lead the organization this coming year.

AT LEFT: Franklin L. Troost, M.D., of Holt, receives his citation as "Michigan's Outstanding Physician of 1965" from the MSMS House of Delegates. He was cited for civic service and medical leadership.

GAS IS BEST
SALUTE MEDICS
100TH YEAR

ABOVE: The huge Detroit Edison Company sign on the Expressway told motorists about the Centennial.

AT LEFT: Luther R. Leader, M.D., left, is installed as the 101st President of MSMS at the Centennial Banquet. Going out of office as the 100th President is Oliver B. McGillicuddy, M.D., right.

AT RIGHT: An abstract painting by Mrs. Paul Lowinger, Detroit, left, was judged the "Best of the Show" at the Auxiliary art exhibit in Cobo Hall. Viewing the painting is Edward F. Kickham, M.D., Saginaw.

BELOW: Several hundred old photographs of MSMS activities attracted considerable attention in the Family Album exhibit room at Cobo.

LOWER RIGHT: Among the 24 firms and organizations cited on Business-Industry-Communications Day was the Michigan Chapter of the American Writer's Association; the award was accepted by C. Howard Ross, M.D., right, President, from A. Carl Stander, M.D., MSMS Councilor.

ABOVE AT LEFT: Past President of the AMA, Edward R. Annis, M.D., speaker at the Medicine and Voluntary Health Day Luncheon, takes time to visit with Miss Terry Drouillard, President, Saginaw Future Physicians Club, and Robert Mason, M.D., club advisor.

ABOVE AT RIGHT: Among the distinguished speakers for the House of Delegates was Walter H. Judd, M.D., former U. S. Congressman.

ABOVE: A special Centennial Citation to Michigan Medical Service is received by Sidney Adler, M.D., left, MMS President, from James J. Lightbody, M.D., MSMS Speaker, during the Century Luncheon, hosted by MMS.

AT RIGHT: The special Citation to Michigan Hospital Service is received by Wm. S. McNary, MHS President, from Speaker Lightbody.

ABOVE: Governor Romney, speaker at the Medicine and Government Day Luncheon, was surrounded by broadcasters. (See President's Page for portions of the Governor's address.)

AT RIGHT: W. D. Snively, Jr., M.D., right, Executive Vice-President, Mead Johnson Laboratories, shows his speech to N. D. Henderson, M.D., Chairman, MSMS Liaison Committee with Residents-Interns-Senior Students. Mead Johnson was the host for a reception following the special Conference for Interns-Residents-Senior Students.

BELOW: Members of the MSMS House of Delegates take special seats at the Medicine and Religion Convocation which drew 11,000 to Ford Auditorium to hear William C. Menninger, M.D., Rev. John Weaver, and Rev. Paul B. McCleave.

TOP: The MSMS Centennial Citation to S. S. Kresge Company is received by W. E. Sturgis, right, and presented by Orlen J. Johnson, M.D., MSMS Past President.

CENTER: The Citation to the Kellogg Company during the Business-Industry-Communications Day ceremonies is received by E. M. Leaver, right, and presented by Oliver B. McGillicuddy, M.D.

BOTTOM: The Citation to WJBK Radio and TV is received by Harry Lipson, right, from Luther R. Leader, M.D.

ABOVE: A cute blond girl, born without arms, enjoys a lollypop held by her toes during one of the Clinical Demonstrations in the big exhibit hall on "Research and Rehabilitation Techniques at the Mary Free Bed Hospital."

BELOW: Marshall Fredericks, standing left, Bloomfield Hills sculptor, receives a MSMS award from Harold H. Hiscock, M.D., MSMS Council Chairman, during the Medicine and Voluntary Health Day Banquet. Seated at left is Jenkin Lloyd Jones, Tulsa Tribune Editor and banquet speaker. Watching at right is C. Allen Payne, M.D., toastmaster for the banquet.

SOCIETY OF DETROIT

UPPER LEFT: Mrs. Juanita Ferman, right, Jackson, is installed as the new President of the Michigan State Medical Assistants Society by Miss Phyllis Marquardt, out-going President from Kalamazoo.

UPPER RIGHT: Wesley W. Hall, M.D., right, Vice-Chairman, AMA Board of Trustees, who addressed the MSMS House of Delegates, confers with Wm. A. Hyland, M.D., MSMS Treasurer and Chairman of MSMS Delegates to AMA.

AT RIGHT: During the Cultural Center Dinner, Luther R. Leader, M.D., right, receives an award and congratulations to MSMS from Adrian N. Langius, F.A.I.A., President of the Michigan Association of the Professions.

BELOW: Five Past Speakers of the MSMS House of Delegates received inscribed gavels in a ceremony before the Delegates on Medicine and Medical Organization Day. Left to right are J. S. DeTar, M.D., Milan; O. D. Stryker, M.D., Mt. Clemens; J. E. Livesay, M.D., Flint; K. H. Johnson, M.D., Lansing; and H. R. Carstens, M.D., Birmingham.

ENGINEERING SO

AT RIGHT: The MSMS Healthmobile is dedicated at the Centennial Session in special ceremonies. Speakers included Ross V. Taylor, M.D., left, Chairman, County Societies Committee of The Council.

BELOW: Sherman L. Loupee, M.D., Dowagiac, recipient of two citations as the only physician now living who has served in the Michigan legislature, was proud to have his wife and members of the family present at the Medicine and Government Day Luncheon.

ABOVE: Mrs. Dorothy Brandis, Lansing, took home a plaque as the "Outstanding Medical Assistant of the Year" from the Centennial to show to her boss, Arthur L. Stanley, M.D.

AT LEFT: The Detroit Institute of Arts presented a "Doctor-Collects-Art Exhibit" during the Centennial Session. The leader in the project was Alfred Golden, M.D., Detroit, shown with his wife viewing some of the art work loaned by physicians for the show.

ABOVE: Among those receiving the coveted "50-Year Pins" from MSMS President McGillicuddy, right, were Harry E. Lee, M.D., Wayne County; W. S. Jones, M.D., MSMS Past President from Menominee; and U-M Medical School Dean Emeritus—A. C. Furstenberg, M.D.

ABOVE: Reuben L. Kahn, S.D., right, elected into the Michigan Health Council Health Hall of Fame, receives his citation during the Medicine and Voluntary Health Day Luncheon from S. D. Steiner, M.D., Health Council President.

ABOVE: Mrs. Rufus H. Reitzel, center, Mt. Clemens, was installed as the new president of the Woman's Auxiliary to MSMS during their convention at the Pontchartrain. At left is the outgoing president, Mrs. Milton R. Weed, and at right is Mrs. C. C. Long, Ozark, Arkansas, a visiting national auxiliary officer.

AT LEFT: Mrs. Leader admires the MSMS President's Medal following the installation at the Centennial Banquet of Luther R. Leader, M.D., as the MSMS President for 1965-66.

EDITORIAL VIEWS

Who Will Decide? Medicare:

Utilization Review,
Participation,
Fair and Reasonable

By Ross V. Taylor, M.D.
Jackson

"Medicare" in Public Law 89-97 is now an accomplished fact. Even though it may not represent the wishes of the majority of the people, socialized medicine now has a very big foot in the door. Having written the law and forced its passage, some of the Administration's top echelon have achieved a belated recognition that the success or failure of this socialized legislation will be dependent on the physicians. They are the only ones able to supply the professional skill and judgment necessary to take care of the beneficiaries.

John W. Gardner, Ph.D., the newly appointed Secretary of Health Education and Welfare, in a talk prior to the October special session of the American Medical Association House of Delegates, pointed this out as he gave an honest and forthright analysis of some phases of the program and expressed the desire for cooperation and collaboration from the AMA and all physicians in the implementation of Medicare.

Dr. Gardner also pointed out by definition in the law that "the term 'provider of services' means a hospital, extended care facility or home health agency."

Only by keeping this definition in mind can one help to avoid confusion. Hospitals in order to receive reimbursement must become an approved and participating unit. Physicians will be involved in hospital participation as members of the staff and also through the mandatory utilization review committees. Such committees have a valuable function and already exist in many areas. It is important for all physicians to know that these are committees of the hospital staff or County Medical Societies and *responsible only to the staff.* Their function is to be primarily educational and not punitive. However, it must be recognized that the quality and the economics of medical care are inseparable.

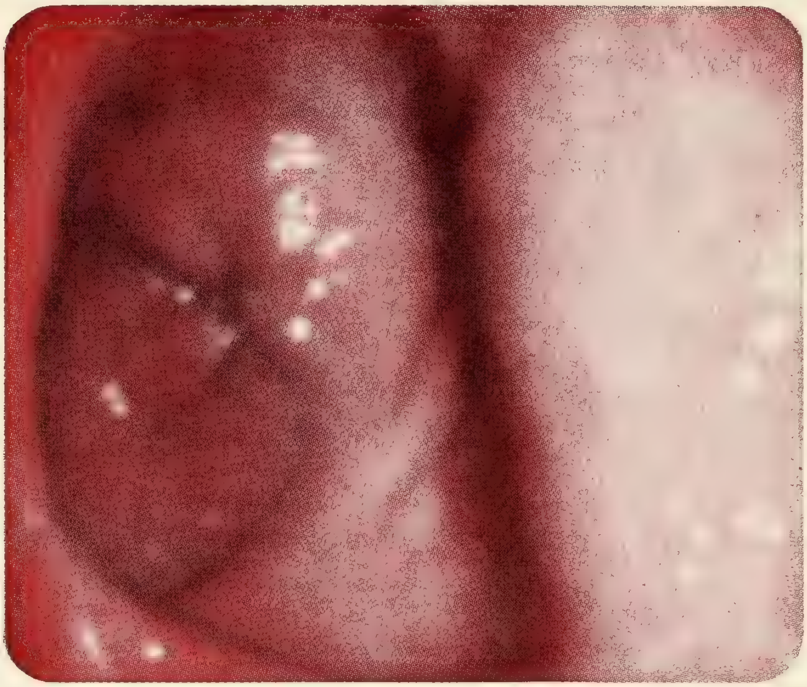
It is unlikely that physicians will refuse care to beneficiaries of Medicare though individually any physician may legally refuse to accept a patient. It does not seem reasonable that a significant segment of the profession will find it practical to "not participate." Should a majority in some area decide to "not participate" and thus create a situation where Medicare beneficiaries might be denied appropriate medical treatment, then undoubtedly additional legislation would be passed. However, the creation of such a situation would seem very unlikely since it would contradict some of the basic ethics of our profession.

Some very thorny issues appear when the question of payment for physician services is reviewed. Physicians are rightfully concerned about this since the old adage is well known that "he who pays the piper calls the tune." Under Public Law 89-97, Title XVIII Part B "Supplementary Medical Insurance Benefits for the Aged," the Secretary is authorized to enter into contracts with carriers who essentially will act as fiscal agents and carry out the functions which involve payments for physicians' services.

The Administration hoped this would be viewed as a financing mechanism operating within the voluntary mechanisms of health care. Since it is to be mandatory, however, it ceases to be a voluntary mechanism.

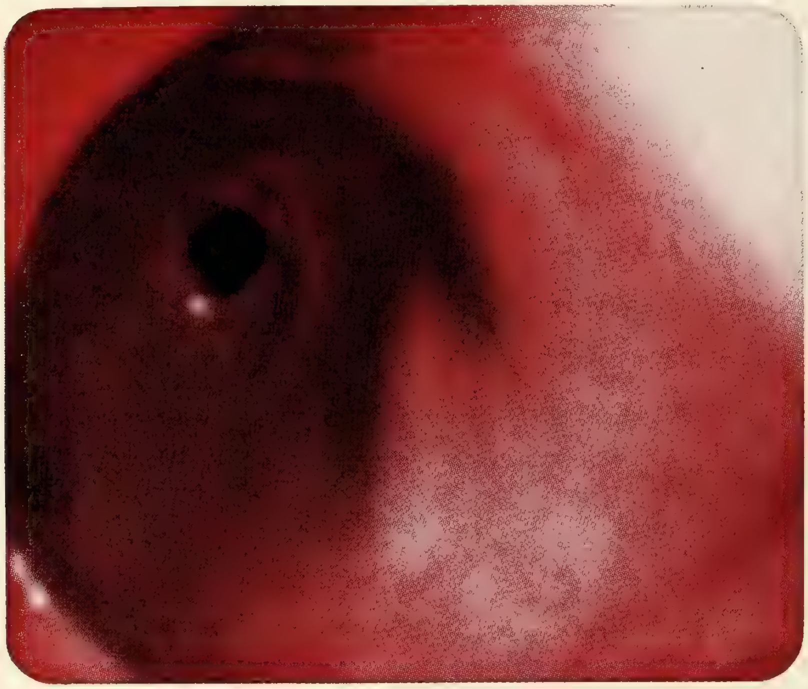
The "carrier" in many areas and probably in Michigan is likely to be Blue Cross and Blue Shield. The carrier is charged with the responsibility to "make determination of the rates and amounts of payments . . . to providers of services and other persons on a reasonable cost or reasonable charge basis. . ." The carrier also "(B) will take such action as may be necessary to assure that where payment under this part for a service

Intragastric photography studies[1]



A/ E. B., male, age 48. Normal antral contraction. Pyloric opening is not seen. It is difficult to differentiate a deep prepyloric contraction from a "pyloric fleurette" or true pylorus.

B/ Same subject after 6 mg. of propantheline bromide intravenously; antral contractions ceased. The pyloric orifice remained open and was easily identified. Better visualization of the antrum was also obtained.



Say you saw it in Michigan Medicine

Now you can see Pro-Banthīne® at work

(propantheline bromide)

Pro-Banthīne is so effective in anticholinergic action that it may be employed in visualizing the entire pyloric region.

In addition to the intragastric photographs, cinegastroscopic studies[2] have demonstrated graphically not only its effectiveness but the superiority of Pro-Banthīne over belladonna alkaloids.

Pro-Banthīne produced complete cessation of gastric, antral and pyloric motor activity with a dose of 6 mg. intravenously. This is approximately one-third the usual oral dose of 15 mg.

Atropine at full normal dosages did not produce such cessation. It required double the usual oral dose of atropine, 0.8 mg. intravenously, to duplicate the aperistaltic action of Pro-Banthīne. This dose of atropine produced pronounced discomfort and tachycardia with ventricular rates as high as 150 per minute.

It is this pharmacologic superiority of Pro-Banthīne which has made it the most widely prescribed anticholinergic in such conditions as peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

Dosage—The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15 mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily.

Side Effects and Contraindications—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.
2. Barowsky, H.; Greene, L., and Paulo, D.: Paper read at Meeting of American Society for Gastrointestinal Endoscopy, Montreal, Canada, May 25-27, 1965.

SEARLE

Research in the Service of Medicine

is on a charge basis, (i) such charge will be reasonable and not higher than the charge applicable for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier and (ii) such payment will be made on the basis of a receipted bill or on the basis of an assignment under the terms of which the reasonable charge is the full charge for the service."

In another paragraph the law states that in determining the reasonable charge there shall be consideration given to the *customary charges* for similar services generally made by the physician as well as the *prevailing charges* in the locality.

A physician having accepted a Medicare beneficiary as a patient has the choice of: making no charge; accepting an assignment; or making the usual charge for his service, and the patient as a beneficiary of Medicare later being reimbursed 80% of the charge unless it does not meet the "reasonable" criteria.

A dilemma is immediately presented to many carriers since existing schedules are frequently unrealistic and yet the law states they cannot vary from their policyholder's contracts. Most of the Blues have inadequate fee schedules. Despite the seeming evasion of the law it has been expressly stated that it is recognized that the medical profession has subsidized the Blues and that the Blues as fiscal agent will not be tied by existing schedules in the Medicare program.

In Michigan, the Michigan Medical Service is using fee schedules which contain admitted inequities, and which have been essentially unchanged since 1957 despite the marked increase during this period in costs of living as well as increased costs of doing business. The Michigan State Medical Society House of Delegates in September approved the 1965 Michigan Relative Value Study. It will take some time for Michigan Medical Service to study and begin to use the new Relative Value Study as a guide for future contracts but this study might serve as a guide for Medicare negotiations. This would seem to have been the intent of the House of Delegates.

The determination of "prevailing" fees in Michigan presents a very difficult problem. The fact that approximately a third of the Michigan population has Blue Shield coverage and that in over 90 per cent of the services the Blue Shield payments are accepted in full would suggest that Blue Shield could establish the "prevailing" charges. But the situation is complicated by other factors. Many physicians are not "participating" physicians with Blue Shield.

Many other physicians, approximately 500 each in three major centers (University of Michigan, Wayne State University, and Henry Ford Hospital), are participating by directive and are actually in salaried situations. This also is true of a good number of other specialties in hospital-oriented practice. The problem of the correction of obvious inequities in existing schedules is another factor of importance.

The final determination of what is reasonable must be made by the Michigan State Medical Society and not by Michigan Medical Service or any other carrier. One mechanism for determination of prevailing fees and one worth study has been demonstrated in pilot studies in several areas. Essentially it consists of every physician listing and filing his own schedule of charges and making his own patient charges for each procedure. This is supposed to permit a variation depending on the type of practice and yet establish a range in which less than 10 per cent of charges fall outside the "fair and reasonable" definition. This mechanism is only valid, however, in areas which have previously offered no, or at least a limited number of, service contracts. Even in those areas it seems probable that the upper limits would soon become generally known and used by all participating physicians so that another fixed schedule would result.

Furthermore, by eliminating the top 10 per cent, based on the individual physician reports, the prescribed limits do not take into consideration the comparative number of times physicians may render the service.

Finally, a way to incorporate some mechanism for future revision would seem almost impossible in this plan and would soon place the physicians in the situation already existing in many areas where attempts to upgrade Blue Shield service contracts are very unsuccessful and frequently depend on the vagaries of a political climate. Relating a Relative Value conversion factor to the cost of living index might be more suitable. Most students of medical economics foresee a future single schedule of charges as likely for everyone without regard to income levels, etc.

More will become known about the administrative details of Public Law 89-97 and the necessary time schedule to implement it by July 1966.

It is vitally important that only the Michigan State Medical Society through its elected representatives determine the fair and reasonable basis for the implementation of Medicare. If necessary, a special session of the House of Delegates of the Michigan State Medical Society must be called. Only the doctors of Michigan can render the necessary services.

Public Law 89-97 has given these services as benefits, but the terms for delivery of the services must remain in the hands of the Michigan State Medical Society. Only in this way will there remain a voluntary basis of professional practice and a free profession bond primarily by its own code of ethics which remains the highest of all professions. Only the physicians can provide the services.

Only a free profession can maintain the quality of medical care.

International Service

By Robert K. Nixon, M.D.
Detroit

It is given to few men to become a Schweitzer, a Seagrave or a Dooley. Total dedication to a lifetime of medical practice in a backward, often primitive area of the world requires sacrifices which only the rare individual can make and resources which equally few possess.

Despite the well nigh impossible obstacles to a career in foreign service or missionary type medicine for the average man, there exists many opportunities for short-term participation by physicians interested in making a contribution to deserving medical programs overseas.

Cognizant of the need and aware of the growing interest of physicians in this domain, the Council of Michigan State Medical Society designated earlier this year the formation of a Com-

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mittee for International Health to explore means to assist in this field of medicine.

The committee has initiated a facility whereby physicians may indicate their particular interest and designate the foreign area and duration which they can serve. An attempt will then be made to match the individual's request with the appropriate project and put the two parties into contact with each other.

Early in October, each member of the Society will receive a questionnaire with covering letter explaining the program. Those who feel they might wish to contribute their talents to one of the many programs available are encouraged to take advantage of this convenient means to satisfy this desire.

Never in the history of man have more humans faced disease and poverty and never have they been so aware of their plight and of the possibility for change. To refuse even in some limited way to help these millions when the means are at hand is to ignore that original spark which ignited our choice of profession and which, though often suppressed through the years, is hopefully never extinguished.

The Council is to be complimented for its pioneering efforts in this area and it is to be hoped that the members' response will provide an example which other medical bodies will follow in the direction of mobilizing latent resources for international medical needs.

THANKS, MENOMINEE

Congratulations are expressed to each member of the Menominee County Medical Society and also to the Society for its excellent support this year to the AMA-ERF.

Each member of the Menominee Society has contributed $100 to the AMA-ERF. Most of the members have made annual contributions, but this was an additional, special effort.

We wonder how many other Michigan component societies can match this accomplishment?

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WARNINGS: Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease; advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

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Expanded PG Programs Offered Soon At Midland, Grand Rapids by MSMS

MSMS members are urged to attend the 20 extramural courses offered across the state this fall by the MSMS Committee on Postgraduate Medical Education.

The PG lectures, usually held in conjunction with a county medical society meeting, began October 5 and will continue through December 9.

"Good doctors never stop studying and will be present at these lecture and clinic programs," declares H. A. Towsley, M.D., Ann Arbor, chairman of the sponsoring MSMS committee.

Attendance increased last year and a new committee idea to offer afternoon clinical programs at the hospital was well received. Such expanded activity is scheduled this year at Grand Rapids, Midland and Marquette.

The Midland County Medical Society will host physicians from surrounding counties for its Clinic Day project, Thursday, November 18. The 2 p.m. clinic at the Midland Hospital offers the following authorities—Reed O. Dingman, M.D., E. Richard Harrell, M.D., Reed M. Nesbit, M.D., John M. Sheldon, M.D., Earl F. Wolfman, Jr., M.D., and H. A. Towsley, all of the University of Michigan, and also Walter P. Work, M.D., Wayne State University. The evening dinner meeting will include a lecture by Doctor Wolfman on "Chronic Ulcerative Colitis—A Surgical Disease?"

An outstanding team of experts will be in Grand Rapids, Thursday, December 9, for the 2 p.m. clinic at Blodgett Hospital. Representing MSMS will be William H. Beierwaltes, M.D., E. Bruce Fralick, M.D., and James L. Wilson, M.D., all of the University of Michigan; and Muir Clapper, M.D., Alan Thal, M.D., and Walter P. Work, M.D., all of Wayne State. The evening dinner program will spotlight Doctor Beierwaltes on "Diagnosis and Treatment of Thyroid Disease" and Doctor Wilson on "Current Concepts in the Production of Congenital Malformations."

All physicians in the Western Michigan area are invited to the Grand Rapids program.

The Marquette program began at 2 p.m., Thursday, October 21, with a clinic at St. Lukes Hospital. MSMS authorities were George H. Koepke, M.D., University of Michigan; Raymond S. Kurtzman, M.D., and Thomas A. Bruce, M.D., both of Wayne State University, and Earl R. Feringa, M.D., Veterans Administration Hospital, Ann Arbor. The evening dinner program featured Doctor Koepke, who spoke on "When Is Physical Medicine Indicated?" and Doctor Bruce on "What's New and Usable in Cardiology."

Following is a list of the Lower Peninsula lectures for November and December: Alpena, November 4; Grand Rapids, December 9; Jackson, November 16; Midland, November 18; Petoskey, November 11; Port Huron, November 9, and Traverse City, November 9. Lectures were offered in October at Battle Creek, Grayling, Lansing, Muskegon and Niles.

In the Upper Peninsula, the series was completed in October, serving these communities: Escanaba, Houghton, Iron Mountain, Ironwood, Manistique, Marquette, Menominee and Sault Ste. Marie.

Medical Data Sticker Campaign Under Way

The Michigan Secretary of State has officially approved and authorized the use of "medical data" stickers, which may be placed across the bottom of the reverse side of the newly-revised Michigan Motor Vehicle Operator's Permit.

Doctors of Medicine thus have a unique opportunity to provide an additional valuable benefit to their patients while engaging in a statewide Michigan State Medical Society public service program.

In a letter to MSMS members, President Luther R. Leader, M.D., urged every physician to regularly make use of the "medical data" stickers wherever appropriate.

The stickers, designed by MSMS and subsequently approved by the government agency, carry the society's name, the words "medical data" and sufficient blank space for any comment which the physician deems advisable. The fact that they will become an integral part of the driver's license will, it is hoped, tend to increase the number of persons carrying vital medical emergency data on their persons.

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CARDIOVASCULAR DAY, NOV. 6, IN DETROIT

Michigan's first state-wide cardiovascular conference, designed to be "a summary of progress in cardiovascular research and its application to clinical practice" has been scheduled for all day Saturday, November 6, in the Student Center, Mercy College, Southfield (M 39) and West Outer Drive in Detroit.

Sponsored by the Michigan Heart Association, the Michigan State Medical Society and the Michigan Board of Health, the program will offer eight panel discussions.

Separate sessions will be held for physicians and nurses and for the general public. Nineteen professional agencies and societies co-operated in the presentation. There will be free tests for hypertension and for blood sugar and cholesterol levels.

The program follows:

9:00-9:45 a.m.—Rheumatic Fever (Prevention, Diagnosis): Moderator, Edward L. Quinn, M.D., Detroit.

9:44-10:40 a.m.—Surgery (Congenital, Acquired, Vascular): Moderator, Harold E. DePree, M.D., Kalamazoo.

10:50-11:35 a.m.—Hypertension (Diagnosis, Treatment): Moderator, Sidney W. Hoobler, M.D., Ann Arbor.

11:45-12:30 a.m.—Stroke (Acute Treatment, Surgery, Rehabilitation): Moderator, E. S. Gurdjian, M.D., Detroit.

12:30-2:00 p.m.—Lunch, Cafeteria Service.

2:00-3:00 p.m.—Coronary Artery Disease (Diagnosis, Treatment, Epidemiology & Prevention, Coronary Arteriography, Anti-coagulants, Radio-isotopes): Moderator, Muir Clapper, M.D.

3:10-4:10 p.m.—Community Service (Public, Voluntary, Academic): Moderator, Sidney E. Chapin, M.D., Dearborn.

4:20-5:00 p.m.—Organ Transplants: Moderator, Richard J. Bing, M.D., Detroit.

5:00-5:30 p.m.—Electronic Instrumentation in Cardiology (Instrumentation, Coronary Intensive Care Units): Moderator, Larry Birch, M.D., Grand Rapids.

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AMA Rejects Moves For Nonparticipation

Michigan had a fine complement of delegates at the Special Session of the AMA House of Delegates, October 2 and 3, when the Delegates voted to reaffirm the Association's position that whether or not to participate in the Medicare Program (Public Law 89-97) is the physician's own choice.

In so doing, the House of Delegates rejected resolutions which proposed that the AMA support or urge nonparticipation in the program. The House of Delegates also voted to continue to have representatives of the AMA meet with members of Federal agencies and departments for the purpose of developing regulations under the law which will help achieve Medicine's objectives in behalf of the public and the profession.

The reference committee, to which all resolutions had been referred, issued the report which included the policy recommendations on participation by physicians and the Association. The report, adopted with only slight modification, also cited the remarks of Association's President, James Z. Appel, M.D., which called for unity within the profession.

The House of Delegates commended the AMA Board, AMA officers, and staff leadership for their roles in combating deleterious legislation.

DOCTORS KURTZ, HARRIS TO LEAD STATE BOARD

Irvin J. Kurtz, M.D., Detroit, is the new president of the Michigan State Board of Registration in Medicine.

Dr. Kurtz replaces Howard H. McNeill, M.D., Pontiac, who served as president the past two years.

Bradley M. Harris, M.D., Ypsilanti, was elected to succeed Bernard A. O'Hara, M.D., Midland, as vice president.

Renamed secretary for a sixth term was E. C. Swanson, M.D., Vassar, who is also president of the Federation of State Medical Boards of the United States.

Michigan M.D. Authors

Albert E. Heustis, M.D., Lansing, "What's So Great About Public Health?" The New Physician, August, 1965.

Donald Dawson, M.D., Pontiac, "The Role of the Medical School in the Development of Academic Careers," The New Physician, September, 1965.

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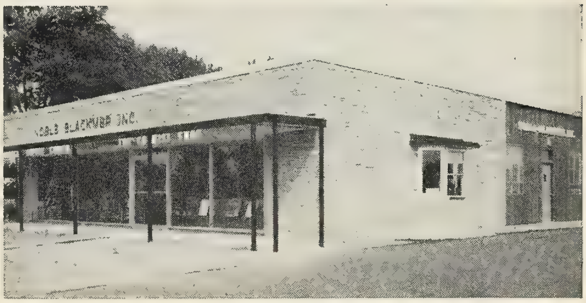

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Abstract of MSMS Council Action

Meeting of September 18, 19, 23, 1965

APPOINTMENTS AND NOMINATIONS

The Council appointed two MSMS representatives to the Mental Health Assembly and transmitted to the governor nominations for vacancies on the State Board of Registration in Medicine after having received suggestions for nominations from members of The Council.

CO-SPONSORSHIP OF CONFERENCE ON CARDIOVASCULAR DISEASE

The Council agreed to co-sponsor, without financial obligation, a conference on cardiovascular disease, on November 6, in Detroit, in cooperation with the Michigan Heart Association and others.

REVISION OF RULES FOR MINIMUM STANDARDS IN HOSPITALS

The Michigan Department of Health was in process of revising its rules and minimum standards for hospitals and was forming an Advisory Committee to operate as a working group to advise on form and content of the revised rules. The MSMS President was authorized to appoint a representative to this advisory committee.

PRINTING OF THE JOURNAL "MICHIGAN MEDICINE"

Council authorized the Publications Committee to explore in depth the competitive bids from three printers who desired to publish the Journal of MSMS.

DISSEMINATION OF JOINT STATEMENT ON NURSING FUNCTION

Council authorized the transmitting of the MSMS and Michigan Nurse Association joint statement on nursing function to all chiefs of staff of Michigan hospitals and to the Board of Registration in Medicine.

REPORT OF MICHIGAN MEDICAL SERVICE

The report by the President of the Michigan Medical Service included comments on the implementation of Medicare, Class II services rendered in a hospital remaining as a professional benefit, utilization control and the Michigan Relative Value Study.

HOUSE OF DELEGATES ELECTIONS

At its Thursday meeting, The Council welcomed the following officers elected by the House of Delegates: President-Elect, C. Allen Payne, M.D.; speaker James J. Lightbody, M.D., Vice-speaker Louis F. Hayes, M.D.; Councilors Ralph R. Cooper, M.D.; John J. Coury, M.D.; Eugene R. Elzinga, M.D.; Robert J. Mason, M.D.; John R. Pedden, M.D.; Edward H. Rodda, M.D.; A Carl Stander, M.D., and Milton R. Weed, M.D.

REORGANIZATION OF THE COUNCIL

Re-elected as The Council Chairman was Harold H. Hiscock, M.D.; Robert J. Mason, M.D., was re-elected as Vice Chairman of The Council. Also re-elected as Chairman of County Societies Committee was Ross V. Taylor, M.D., and Chairman of the Publications Committee, Bradley M. Harris, M.D. Elected as the new Chairman of the Finance Committee was Robert K. Whiteley, M.D., of Detroit.

AMA NATIONAL ORIENTATION CONFERENCE ON PUBLIC LAW 89-97

Members of The Council who were able to attend were authorized to be present at the AMA National Orientation Conference on the Medicare Law in Chicago on October 1. This meeting preceded the special convention of the AMA House of Delegates and was designed to explain the current status of Medicare and plans for implementation.

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- Rehabilitative services for geriatric and convalescent patients
- Medico-Legal counsel.
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Hospital Stay In Michigan Below Average in Nation

Materials for the Medical Socio-Economic Section of MICHIGAN MEDICINE are provided by Richard M. Campau, MSMS Research Director.

Among the interesting details about Michigan hospitals just released by the Michigan Hospital Association is the fact that the average Michigan patient stayed a slightly shorter stay than the average patient across the nation.

The Michigan patient stayed 7.3 days in the voluntary short-term hospital, whereas the national average length of stay was 7.6 days.

Other Michigan statistics included:

Of the average 69,240 patients in Michigan hospitals on any given day in 1964, 15.2 per cent were in federal, state and local government hospitals *other* than psychiatric, 25.3 per cent in short-term general hospitals, 6.2 per cent in long-term general and other special hospitals, and 5.2 per cent in osteopathic hospitals.

Although 1.1 per cent of all admissions were to psychiatric hospitals in 1964, a total of 48.1 per cent of all patients in Michigan hospitals on any given day were in psychiatric institutions, a decrease of 2.1 per cent from 1963.

* * *

HOSPITAL ADMISSIONS throughout the state increased in 1964 with 1,332,028 patients, an increase of 107,969 over the 1963 total of 1,224,059 patients. The figures also disclosed that during any day in 1964, there was an average of 1,985 newborn infants in Michigan hospitals.

The number of births recorded in Michigan in 1964 reflected the steady decline of recent years. There were 2,945 fewer births in 1964 than in 1963.

SOCIO-ECONOMIC

Patient care expenditures for 1964 came to $547,844,000 as compared to $538,256,000 in 1963, an increase of $9,588,000 or 1.8 per cent. The 1963 figures were $28,000,000 or 5.5 per cent higher than the 1962 total of $510,130,000.

Michigan voluntary short-term general hospitals required 254 full-time hospital employees to meet the needs of every 100 patients. The 1964 total represents an increase of three employees for every 100 patients over the 1963 ratio of 251 employees to every 100 patients.

* * *

THE AVERAGE HOSPITAL investment for the daily care of a patient in a Michigan voluntary, short-term general hospital in 1964 was $45.20, while the national average for the same type of hospital was $41.58.

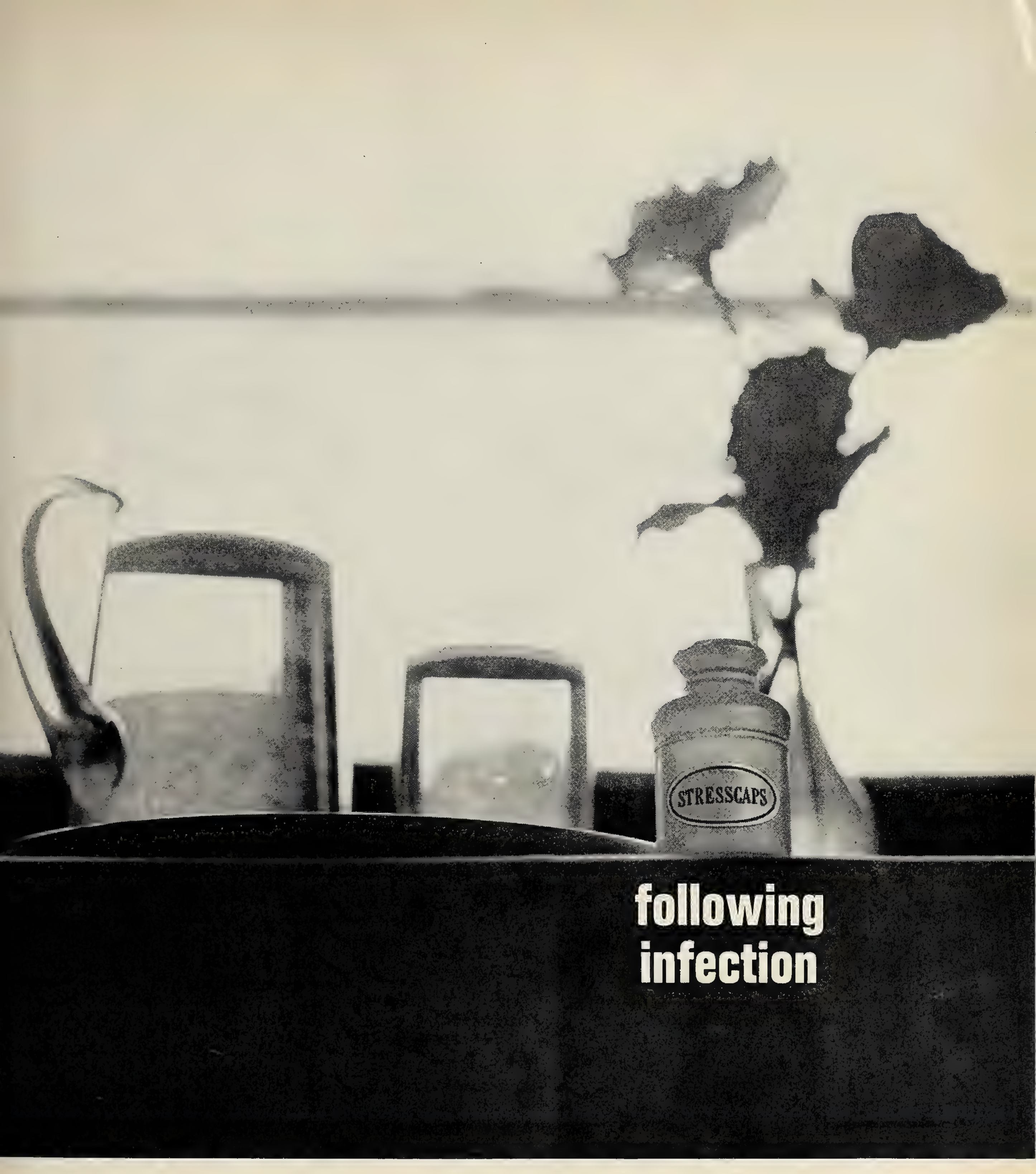
The total income from patient revenue, including third-party payers, in non-profit voluntary hospitals last year in Michigan was $284,436,000, while total expenditures came to $288,317,000, a deficit for the year of $3,881,000. The average patient revenue loss for 1964 was 61 cents per patient day, a significant decrease from the average patient revenue loss of $1.15 per patient day in 1963.

* * *

ON THE AVERAGE, for every dollar spent in providing patient care in Michigan's non-profit general hospitals in 1964, 4.1 per cent was for housekeeping; 10.8 per cent for dietary; 3.8 per cent for pharmacy; 1.3 per cent for medical records; 1.7 per cent for anesthesiology; 6.7 per cent for laboratory; 5.6 per cent for radiology; 12.3 per cent for administration and general supervision; 0.5 per cent for inhalation therapy; 5.5 per cent for medical-surgical and intern-resident services; 5.8 per cent for plant operation; 2.6 per cent for laundry and linen service; 30.4 per cent for nursing service, education, operating room and delivery; and 8.9 per cent for other expenses such as social service, blood bank, ambulance, out-patient services and depreciation.

ELECTRONIC MARKET BOOMS

The medical electronics market is booming. *Electronics* magazine reports that the National Institutes of Health plan to purchase $130-million worth of electronic instrumentation during the next three years. The Federal government is the biggest customer in the medical electronics market, estimated at $500 million this year.



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ANCILLARY SECTION

12 Elected to Blue Shield Board

Twelve men were elected to the Board of Directors of Michigan Medical Service at the corporation's annual meeting, September 21, at Cobo Hall, Detroit. The meeting was held in conjunction with the centennial session of the Michigan State Medical Society.

Elected were Victor M. Zink, General Motors Corporation, Brock E. Brush, M.D., A. Jackson Day, M.D., Philip J. Huber, M.D., and Julian Priver, M.D., Sinai Hospital, all of Detroit; Harold D. Dykhuizen, M.D., Muskegon; James D. Fryfogle, M.D., Southfield; Louis F. Hayes, M.D., Gaylord; Fred C. Ryan, M.D., Kalamazoo; C. J. Tupper, M.D., Ann Arbor; Walter J. Zimmerman, M.D., Royal Oak, and Kenneth E. Wolz, Saginaw General Hospital.

All members were elected for three-year terms with the exception of Doctor Priver, and Mr. Wolz, who were named for one-year terms.

Winners Reported For Art Exhibit

Art work by the wives of two Detroit physicians won top honors at the 1965 Doctors' and Wives' Art Exhibit during the MSMS Centennial Session at Cobo Hall.

An abstract painting by Mrs. Paul Lowinger, of Detroit, received the "Best in Show" recognition from the judges, while another painting by Mrs. Samuel Mendoza, of Detroit, was voted by the viewers as the "Most Popular."

The work was divided into six classifications, with ribbons awarded as follows:

Oil

First—Mrs. Paul Lowinger, Detroit
Second—Mrs. Chester Kirlaski, Grosse Pointe
Third—Leonard Stern, M.D., Detroit
Honorable Mention—Mrs. Henry Small, Detroit; and Mrs. Lawrence Stocker, Detroit

Watercolor

First—Gerhard Bauer, M.D., Ann Arbor
Second—Mrs. Paul Lowinger, Detroit
Third—Julia (Mrs. John) Caldwell, Birmingham

Sculpture

First—L. Jerome Fink, M.D., Bloomfield Hills
Second—Mrs. Adrian Neerken, Kalamazoo
Third—Mrs. Douglas Chandler, Oak Park

Ceramics

First—Mrs. Burton Bacher, Huntington Woods
Second—Mrs. John Shek, Saginaw
Third—Mrs. Joseph Eschbach, Dearborn

Drawings and Prints

First—Mrs. Lee Carrick, Grosse Pointe
Second—Mrs. Ralph Cash, Oak Park

Three-Dimensional Weaving

First—Mrs. Maurice Seevers, Ann Arbor
Second—Mrs. Reuben Meyer, Detroit

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by getting away from frigid weather

. . . but if your patient can't get away, relieve sneezing, running nose, and congestion of colds and sinusitis all day or all night with one

ORNADE® SPANSULE® CAPSULE
Trademark brand of sustained release capsule

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Summary of contraindications, cautions and side effects: Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction or bladder neck obstruction. Use with caution in the presence of hypertension, hyperthyroidism, or coronary artery disease. Drowsiness; excessive dryness of nose, throat or mouth; nervousness or insomnia may occur on rare occasions but usually are mild and transitory.

Before prescribing, see SK&F product Prescribing Information.

Smith Kline & French Laboratories

Traces Growth of MSMAS

by Phyllis Marquard, Past President
Michigan State Medical Assistants Society

In the fall of 1958 a small group of medical assistants throughout Michigan met in Grand Rapids and formed the Michigan State Medical Assistants Society. Officers were elected and a Constitution and By-Laws were adopted.

The objectives of this Society remain today:

A. To inspire its members to render honest, loyal and more efficient service to the profession and to the public which they serve.

B. To strive at all times to cooperate with the medical profession in improving public relations.

C. To render educational services for the self-improvement of its members and to stimulate a feeling of fellowship and cooperation among its societies.

D. To encourage and assist all unorganized medical assistants in forming local societies.

E. This Society is hereby declared to be non-profit. It is not, nor shall it ever become, a trade union or collective bargaining agency.

* * *

THERE ARE NOW 23 county societies affiliated with the Michigan State Medical Assistants Society and with the American Association of Medical Assistants, with an active membership of 882 members. In September, 1965, we participated in our second session of the House of Delegates with 95 delegates in attendance.

Without the organization of MSMAS and AAMA the educational services, such as in-service training programs, leadership training seminars and the educational programs, would not be possible. The establishment of the certification program indicates the enthusiasm of the medical assistant to achieve a better understanding of her job and will indicate to the doctor her ability and knowledge.

* * *

TODAY'S MEDICAL assistant is interested in doing a better job for her employer and continuing her education. She is not satisfied with just a "job." She has a vital interest in the patients, public opinion and legislation. Through her contacts with this Society you will find that she is well informed in the proper method of filling out insurance forms, correct telephone technique, courtesy, understanding and housekeeping and will serve you better.

All of these opportunities are open to YOUR medical assistant, which will ultimately benefit YOU. We accept Doctor McGillicuddy's challenge to do even more to enhance the total medical profession. (See the President's message, MICHIGAN MEDICINE, July issue.)

We sincerely hope that we will continue to merit your support and confidence.

Hygroton®
brand of chlorthalidone

the longest-acting diuretic

Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

*Dorhout Mees,E.J.,and Geyskes, G.G.: Acta med.scandinav. 175:703,1964.

Photos: A 59-year-old woman with hypertensive cardiovascular disease and edema resistant to low-salt diet and bed rest. The patient lost 8½ lbs. in one week with a single tablet daily of Hygroton, brand of chlorthalidone.

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Division of
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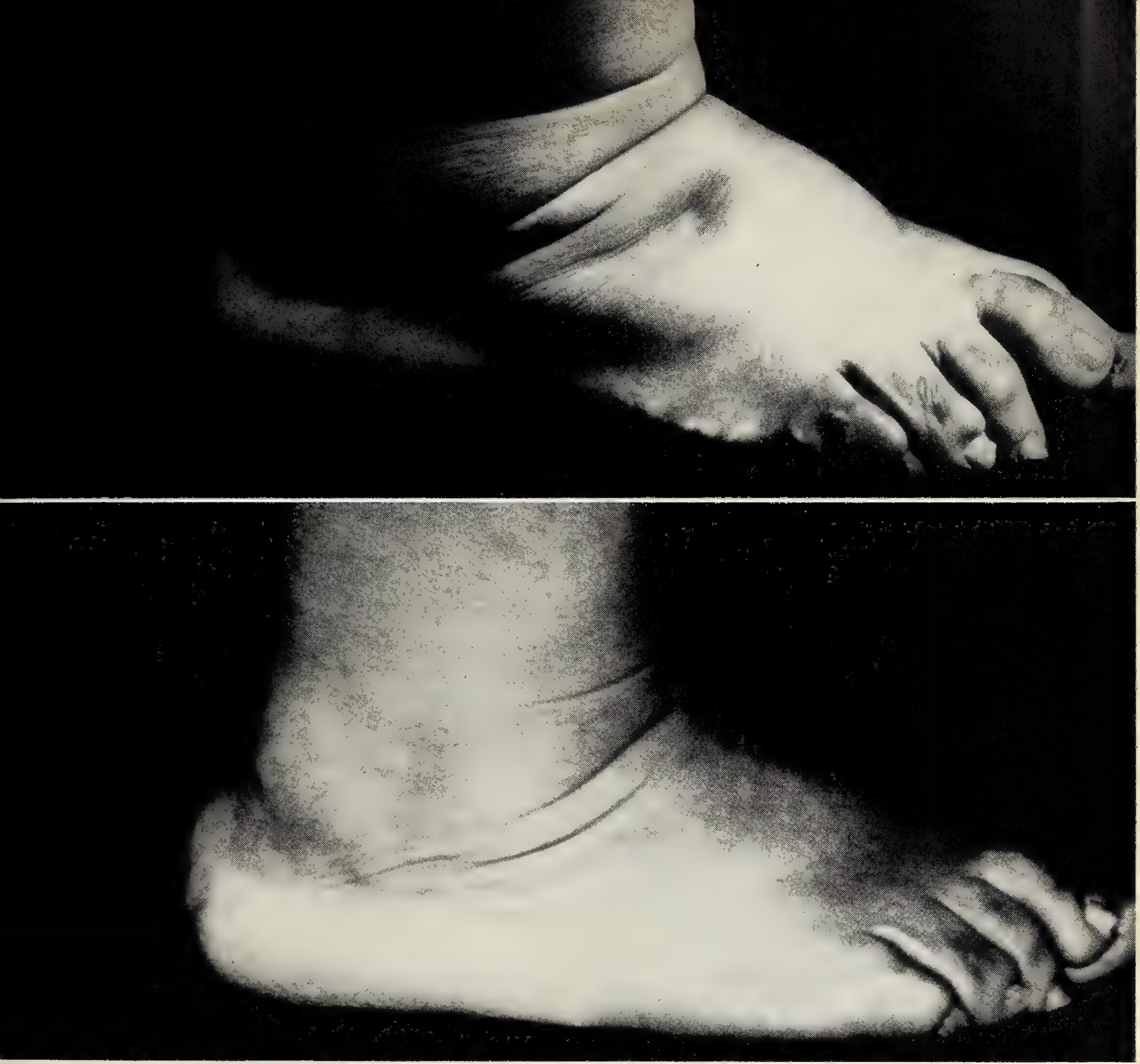

good riddance

Hygroton, brand of chlorthalidone, gets rid of edema efficiently. Your edematous patients will generally need far fewer tablets than with most diuretics. And they'll generally save more on prescription costs. One tablet a day is a popular dosage. So is one tablet every other day. You may even find half a tablet three times a week does the job. No other diuretic works as long. And none has as much natruretic activity per tablet.* For good riddance of edema with the least number of tablets, prescribe Hygroton, brand of chlorthalidone.

Hygroton® brand of chlorthalidone

Geigy

Medical Self-Help Project Provides Valuable Training

By the Michigan Department of Health

One segment of Civil Defense activities has generated some enthusiasm and has involved increasing numbers of people throughout the country. That is the Medical Self-Help training program which was developed several years ago by the Public Health Service in cooperation with the American Medical Association's Council on National Security and Committee on Disaster Care.

Since the beginning of this program in 1963, Michigan has been among the leaders in the states in terms of the number of people enrolled in Medical Self-Help.

* * *

CURRENTLY, some 30,000 Michigan people have completed the course. The ultimate goal is to train one member of each Michigan family, or about 2.2 million persons. The responsibility for developing and promoting this program in Michigan is focused in the Michigan Department of Health's Division of Special Medical Services.

The purpose of Medical Self-Help training is to teach people that they can survive disaster—whether a natural disaster or a thermonuclear attack—even when professional medical help may not be available for days or even weeks. Thus the lessons were developed so they could be taught by non-professional people under medical direction, and be understood and learned by the average person at the junior high school level. Obviously, the lessons had to go beyond the aims of first-aid training which is geared to immediate aid anticipating the arrival of a physician. Medical Self-Help, on the other hand, is geared to the kind of aid needed when a physician or other organized medical service is not available for an extended period of time. Under no circumstances, however, is it a "do-it-yourself" medical kit to be used when competent medical care is available.

Many agencies, public, private, and voluntary, are supporting this program at the national, state, and local level. Here in Michigan, the Red Cross, Michigan State University Extension Service, the State Nursing Association, and local medical societies among others, have provided guidance and leadership in many communities as well as providing instructors for various aspects of the course.

* * *

THE PROGRAM itself consists of 11 lessons requiring 16 hours of class time. They are Radioactive Fallout and Shelter, Healthful Living in Emergencies, Artificial Respiration, Bleeding and Bandaging, Fractures and Splinting, Transportation of the Injured, Burns, Shock, Nursing Care of the Sick and Injured, Infant and Child Care, and Emergency Childbirth. To make the conduct of the course as simple and as standardized as possible, a

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The new WELCH ALLYN instrument case that offers you far greater

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The Sandura Case is molded in reinforced material to stand great shock or abrasion, with tarnish-proof soft rubber lining which protects instruments from shock. The entire case can be washed or sterilized with alcohol.

ILLUSTRATED—Welch Allyn Otoscope-Ophthalmoscope Set No. 983, complete with Sandura Case

MEDICAL SUPPLY CORPORATION

1421 E. Eight Mile Road **566-8686 547-8100** **Ferndale, Michigan**

training kit is provided which contains everything an instructor needs to teach the classes: an instructor's guide, lesson books, Family Guide—a reference manual for emergency health care, examination question booklets and answer sheets, filmstrips, and a series of motion pictures on each of the subjects.

Undoubtedly one of the reasons the Medical Self-Help program has aroused more public interest than any other aspect of Civil Defense, is that, although it was developed primarily to meet the need for preparedness for an all-out attack on this country, it also has an application in localized natural disasters such as floods, hurricanes, blizzards and tornadoes. There have already been reported a number of situations whereby persons who have completed Medical Self-Help have been able to save lives as a result of skills and knowledge learned during the course.

* * *

WHILE THE Federal Government supplies all the Medical Self-Help training materials, implementation of the program is a state responsibility. Each state has a medical self-help coordinator responsible for the administration of the program in accordance with the state Civil Defense plan. In Michigan, over-all responsibility for Civil Defense rests with the state police but the medical aspects of Civil Defense are the responsibility of the State Health Department.

Medical Self-Help materials are available from local health departments and local Civil Defense offices. For local information on Medical Self-Help, see these agencies first. If additional information is needed, write to Medical Self-Help, Division of Special Medical Services, Michigan Department of Health, Lansing, Michigan 48914.

U-M Selects Doctors For Awards, Grants

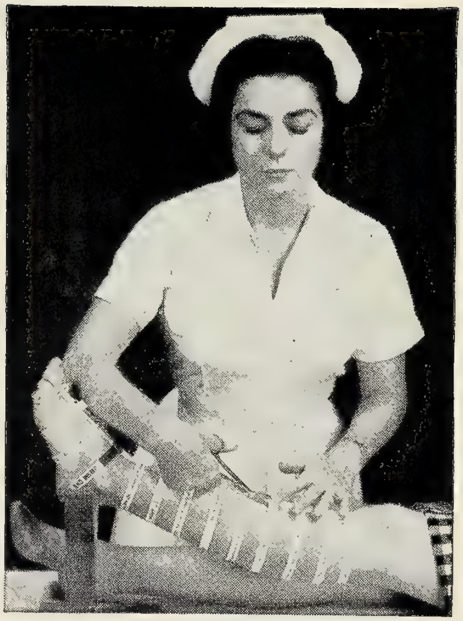
At the annual University of Michigan faculty awards program, one physician received a Distinguished Faculty Achievement Award and another a distinguished Service Award.

Among the recipients for the Distinguished Faculty Achievement Award of $1,000 each was Fred J. Hodges, M.D., recently retired as chairman of the department of radiology. He was cited by MSMS at the Centennial Session with a "Certificate of Commendation."

Paul W. Gikas, M.D., assistant professor of pathology, received a Distinguished Service Award of $500, in part for his interest in automobile safety design. Doctor Gikas presented a clinical demonstration on this subject at the Centennial Session.

"Things are not worse; it appears that way because communications are better."

—F. J. L. Blasingame, M.D.
AMA Executive Vice President



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"...it is extremely difficult and sometimes impossible to differentiate between 'pure depression' and anxiety and it is questionable whether depression without a certain degree of anxiety really exists."

Lehmann, H. E., Canad. Psychiat. Assn. J. *4(S)*: 1-12, 1959

anxiety
depression
anxiety
depression

An antidepressant designed for the clinical realities of office practice

As many physicians have reported, the large majority of neurotic depressed patients suffer from both depression and anxiety. It may be difficult to decide whether these patients are primarily depressed or primarily anxious. And yet drug treatment of only the symptom which seems more prominent may exacerbate the untreated element of the depression complex.

Consequently, it would seem that therapy specifically aimed at both the depression and associated anxiety and tension should increase success in treatment.

This is one of the important reasons why 'Deprol' has proved particularly helpful. For 'Deprol' acts rapidly both to lift the mood and to relieve the associated anxiety, tension and insomnia.

And side effects, at recommended dosage, have been infrequent and generally readily controlled.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular. CD-5749

Deprol® meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

WALLACE LABORATORIES / Cranbury, N. J.

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Member American Hospital Association
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MSU Medical Classes to Begin

Michigan State University has announced it will open its two-year college of human medicine in September 1966, with a class of about 20 students.

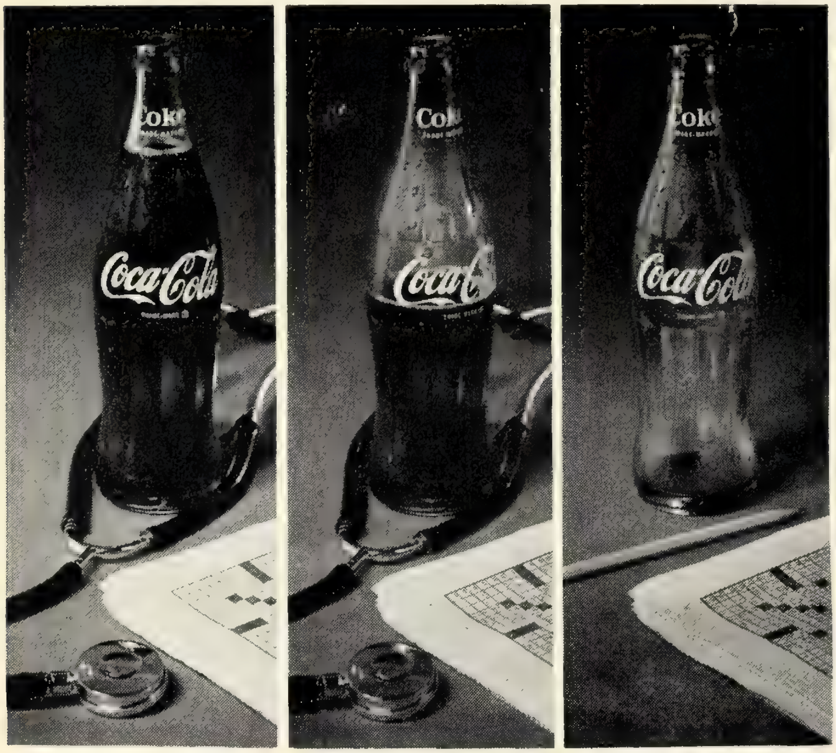
The program has been scheduled to open this fall, but a delay was recommended by the liaison committee of the Association of American Medical Colleges and the American Medical Association, which accredits the nation's medical schools.

The accrediting group recommended that more time be taken to complete physical facilities and recruit staff members.

The accrediting group has sent a letter to the U. S. Commissioner of Education giving him "reasonable assurance" that accreditation of MSU's medical school will be possible when the first class graduates.

The letter enables MSU to apply for federal money for medical school construction.

The medical unit has received more than $5 million in grants from private foundations and federal agencies.



11:47 pm 11:53 pm 12:06 am

The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say things go better with Coke

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$2\frac{1}{2}$-3 times more potent than papaverine with a longer duration of action

NON-NARCOTIC

SPACOLIN™

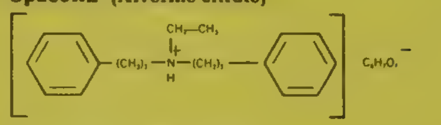
(Alverine citrate)

is a potent smooth muscle antispasmodic particularly effective in relieving spastic colon* and spasm of the biliary tract.

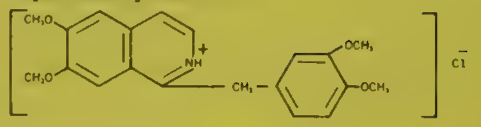
*"The diagnosis is based upon a history of catharsis or enema habit, dietary indiscretion or emotional strain, generalized or lower abdominal distress of the type described, abnormality of the bowel movement and tenderness along the course of the colon." *Cecil and Loeb, A Textbook of Medicine, Tenth Edition*

The chemical structures of Spacolin, Papaverine and Atropine are as follows:

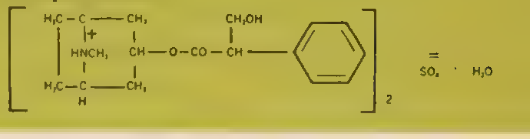
Spacolin (Alverine citrate)



Papaverine Hydrochloride



Atropine Sulfate



SPACOLIN™ *(Alverine citrate)*

- A specific musculotropic counter-spasmodic.
- NOT an anticholinergic, therefore, has no atropine-like side effects.
- In man, its spasmolytic effect is two and one/half to three times stronger than papaverine with a longer duration of action.
- Neurotropic effect only 1/150 that of atropine.
- Has little or no effect on normal muscle tonicity and motility.
- Specific effect on the *sphincter of Oddi.*
- Mild local anesthetic effect and decreases gastric acidity.

the interesting results *in vitro* and *in vivo* with

NON-NARCOTIC **SPACOLIN™** **120 mg. tablets**

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the potent musculotropic counter-spasmodic $2\frac{1}{2}$-3 times stronger than papaverine

IN LABORATORY

Studies with isolated tissue have furnished investigators with important information as to the qualitative and the quantitative activity of certain therapeutic agents. This technique consists of recording the motility of a segment of rabbit ileum suspended in Tyrodes solution at a constant temperature of 37.5°C. The movements of this smooth muscle strip are recorded on a kymograph. The rabbit ileal muscle is remarkably sensitive to spasm-producing drugs. Once a spasm has been initiated, additions of a very small quantity of a musculotropic agent produces an immediate relief of the spasm or relaxation of the muscle. The study of SPACOLIN along these lines indicated the following:

1. SPACOLIN has little or no effect on normal smooth muscle tonicity. The addition of Spacolin to a normal ileum muscle strip does not change the muscle tonus or contraction.

2. SPACOLIN is a musculotropic counter-spasmodic having an activity more than twice that of papaverine.

3. SPACOLIN is a weak neurotropic spasmolytic agent with an activity of approximately 1/150 that of atropine sulfate.

IN MAN

Double-Blind Study of a Spasmolytic Compound(1)

By ITALO EVANGELISTA, M.D.

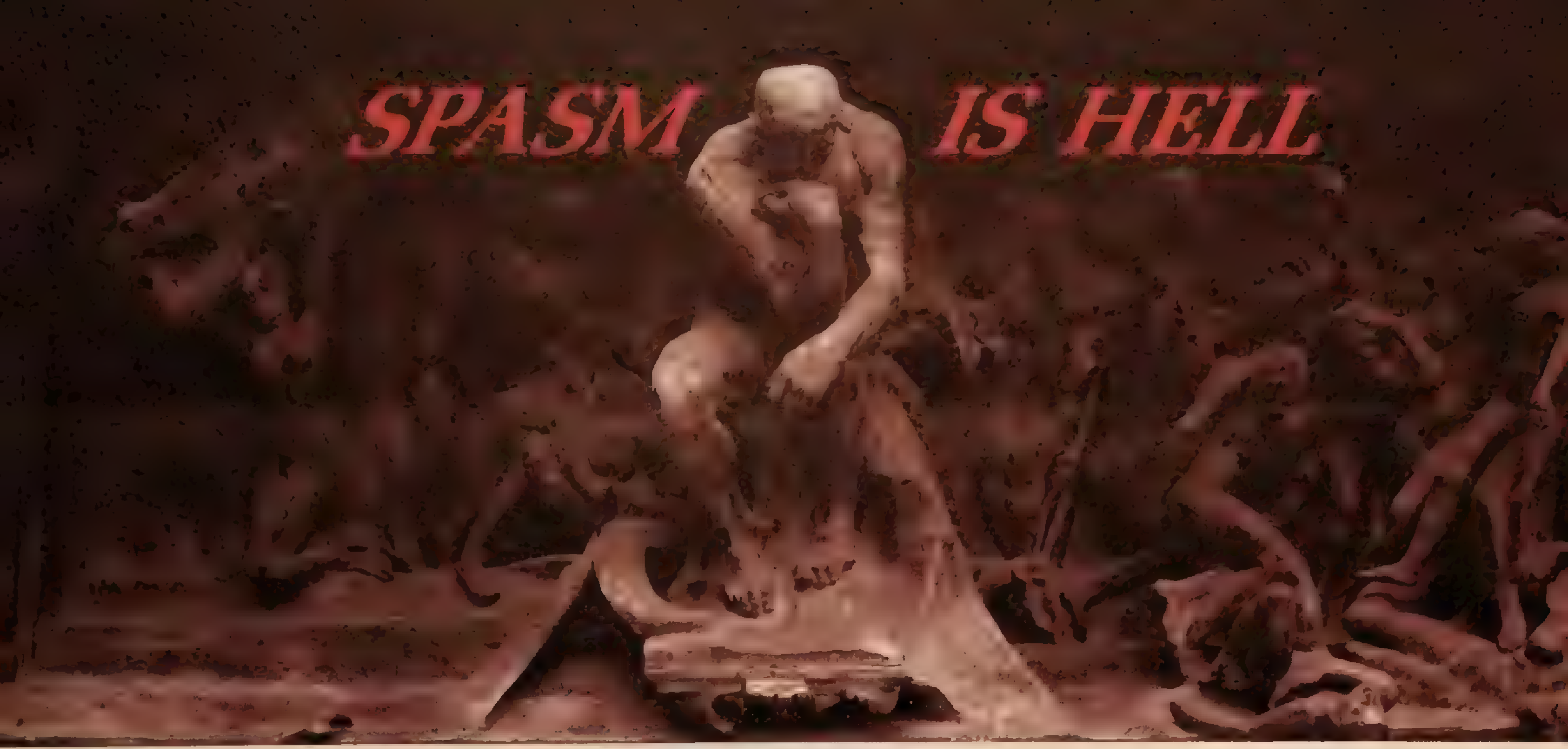
Assistant in Medicine, Tufts University School of Medicine, Boston, Massachusetts; Medical Staff, Cambridge City Hospital, Cambridge, Massachusetts; Malden Hospital, Malden, Massachusetts; Whidden Memorial Hospital, Everett, Massachusetts.

RESULTS*	ACTIVE MEDICATION		PLACEBO	
Excellent	9	80%	1	25%
Good	11		5	
Fair	3	20%	7	75%
Poor	2		12	
TOTAL	25		25	

***Excellent** — complete relief of symptoms during therapy.
Good — definite relief but still aware of symptoms periodically.
Fair - symptoms reduced in intensity but still present
Poor - little or no therapeutic benefit

". . . a definite conclusion could be drawn from the study, namely, alverine citrate (Spacolin), is an excellent aid in the management of spastic gastrointestinal disorders."

(1) To be published



THE GATE OF HELL. — RODIN

SPACOLIN™* IS HELPFUL

(Alverine citrate)

*A SPECIFIC MUSCULOTROPIC COUNTER-SPASMODIC

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(Alverine citrate)
120 mg.
KEEP BOTTLE TIGHTLY CLOSED
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc.
COLUMBUS, OHIO, U.S.A.

NON-NARCOTIC

For fast relief of spasm

PRODUCT INFORMATION

Each tablet contains: Alverine citrate (Bis-gamma-phenylpropylethylamine citrate) . . . . .120 mg.

INDICATIONS: Smooth muscle spasmolytic for use in **spastic colon,** spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer†, cardiospasm, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations.

†Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, cardiospasm or pylorospasm, administer tablets 1/2 hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort.

PRECAUTION: Caution is recommended when using in hypotensive patients.

SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

SUPPLIED: Bottles of 100 and 500 — 120 mg. tablets.

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Division of Philips Roxane, Inc., Columbus, Ohio
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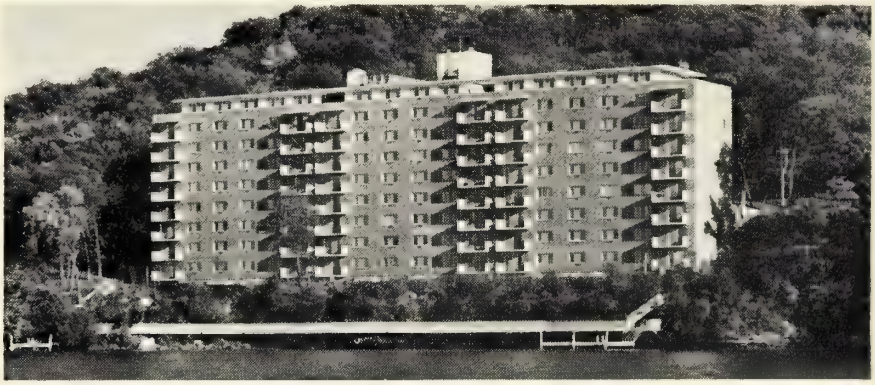

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1817

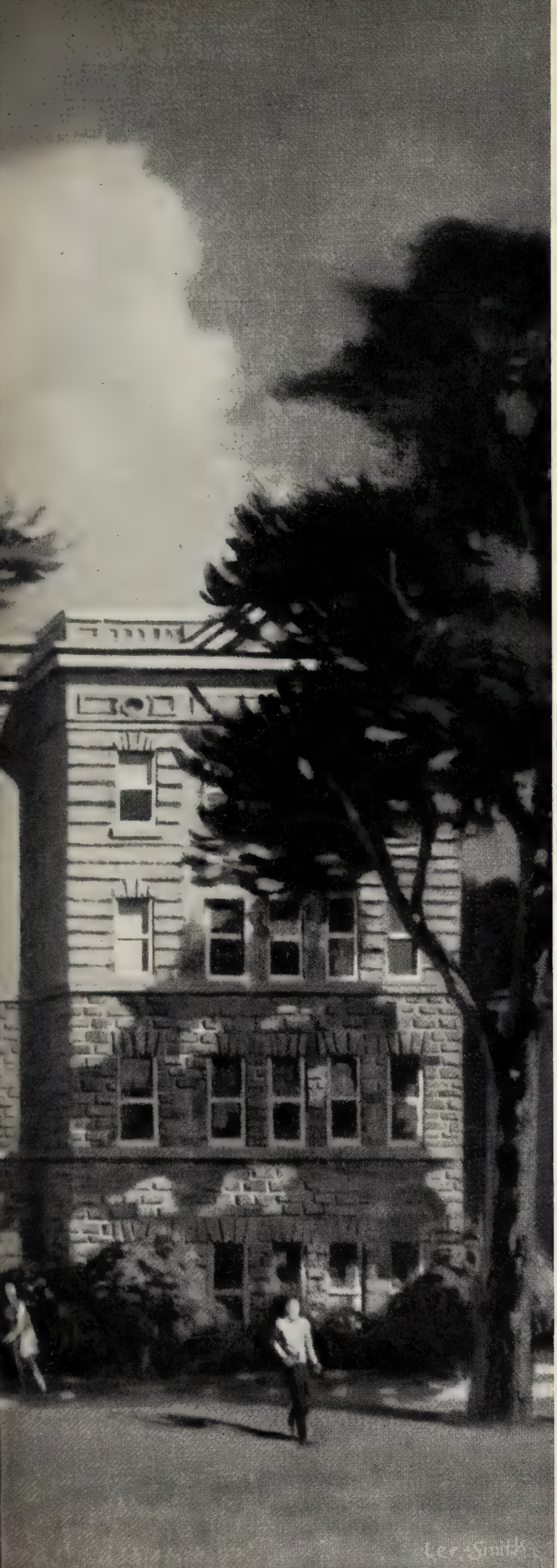
COLLEGIA MEDICA SQUIBB
presents

UNIVERSITY of MICHIGAN MEDICAL SCHOOL

By the turn of the 19th century, a new nation had taken shape . . . founded on rich resources that appeared to be endless . . . and formed by individuals inspired with bold optimism. For three such individuals in Ann Arbor, Michigan—Doctor Zina Pitcher, Doctor Silas H. Douglas and Doctor Abram Sager—the mid-century marked an event of great importance. Their untiring—and until then unsuccessful—efforts to establish a state medical college had finally been rewarded . . . and in October of 1850, ninety-one students entered as the first class at the University of Michigan Medical School.

From its beginning, the University of Michigan Medical School grew rapidly in response to the changing needs of an advancing society. Recognition of the value and necessity of clinical instruction led to classroom demonstrations . . . to laboratory practice . . . to surgical teaching clinics . . . and, in 1869, to the first hospital ever established by a university in connection with its medical school. By this time, enrollment exceeded every other medical school in the United States and, as early as 1870, the opportunity for medical education was extended to women.

This spirit of innovation has always been a tradition of which the medical school is justly proud. And, certainly, it reflects the total commitment to excellence that is synonymous with the University of Michigan Medical School.



UNIVERSITY OF MICHIGAN MEDICAL SCHOOL

THE WEST MEDICAL SCIENCE BUILDING

West Medical is one of many related units that provide a focal point for the instructional activities at the University of Michigan Medical School. The imposing Medical Center was started in 1869, less than twenty years after the medical school was founded. At that time, a faculty residence was converted to a hospital that provided for patients' accommodations, but before very long the need for larger, more permanent facilities became apparent. To halt a movement to relocate the medical school, the state legislature and the citizens of Ann Arbor provided the funds for a new group of hospital buildings. Thus, the foundations were laid for the facilities that, today, serve not only for instruction and research, but also as a major health resource for the entire state.

Almost every University of Michigan student has, at one time or another, crossed the "Diag" in front of West Medical. Artist Hughie Lee-Smith's painting captures the essence of the building and reflects the sentiment with which it is remembered.

Mr. Lee-Smith was recently elected to the National Academy of Design, and is the second American Negro artist to be so honored in the 140 year history of the Academy. He is represented in a permanent collection at the University of Michigan, among a number of others, and his painting of the University's medical school, reproduced on these pages, has been presented to the school for permanent display.

The House of Squibb continuing over 100 years of dedicated service to the medical profession is proud to make this lasting contribution to medicine by paying tribute to the University of Michigan Medical School and all the great schools of medical education in America through the Collegia Medica program.

SQUIBB Squibb Quality—the Priceless Ingredient

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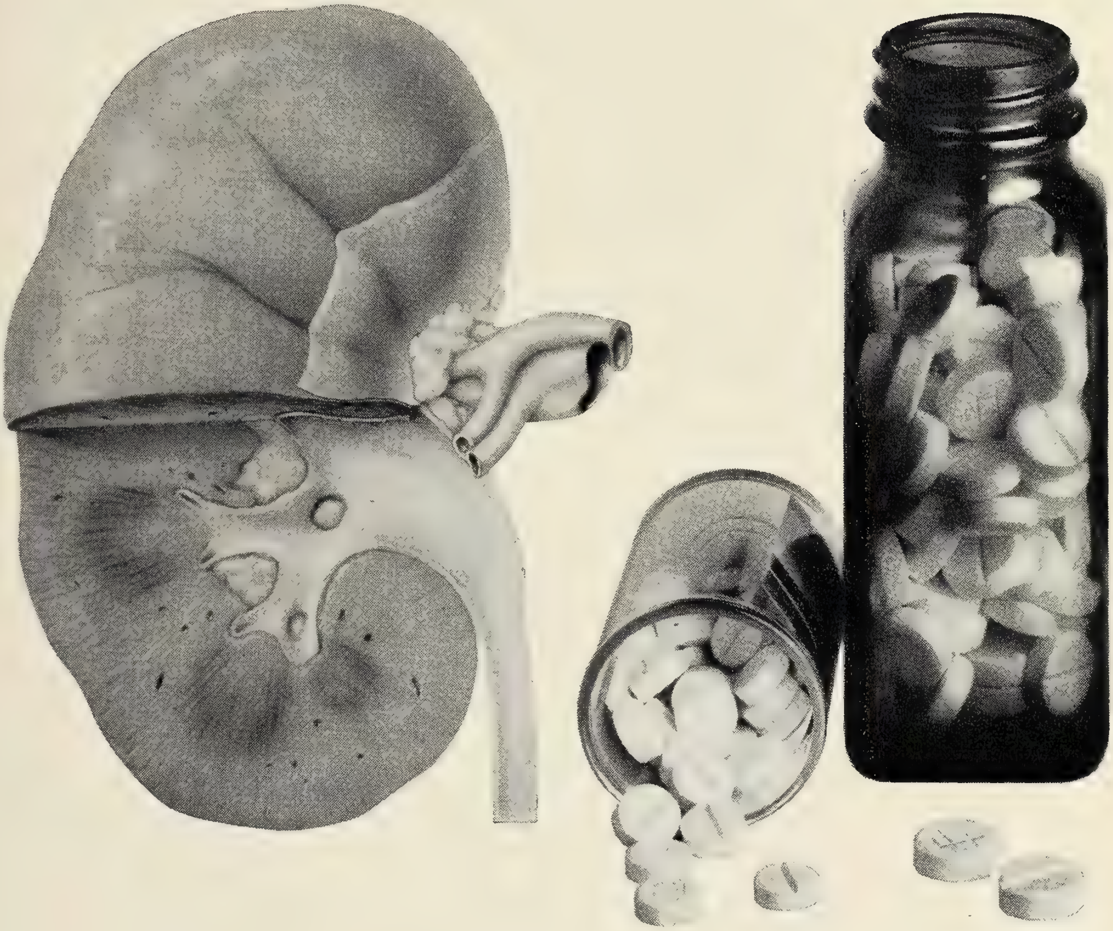

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IN THIS ISSUE: SCIENTIFIC ARTICLES ABOUT THE HIGH RISK OBSTETRICAL PATIENT, SEVERE PSORIASIS, AND OTHER SUBJECTS □ PROGRESS ON NEW MSMS JUDICIAL COMMISSION □ NEWS FROM COUNTY SOCIETIES AND ANCILLARY GROUPS □ REVIEW OF WORK OF THE 89TH CONGRESS

December 1965 • Vol. 64 • No. 12

MICHIGAN MEDICINE

the journal of the michigan state medical society

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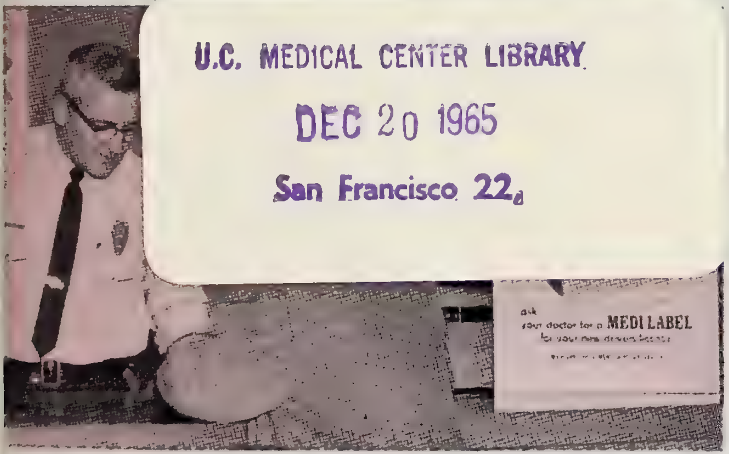
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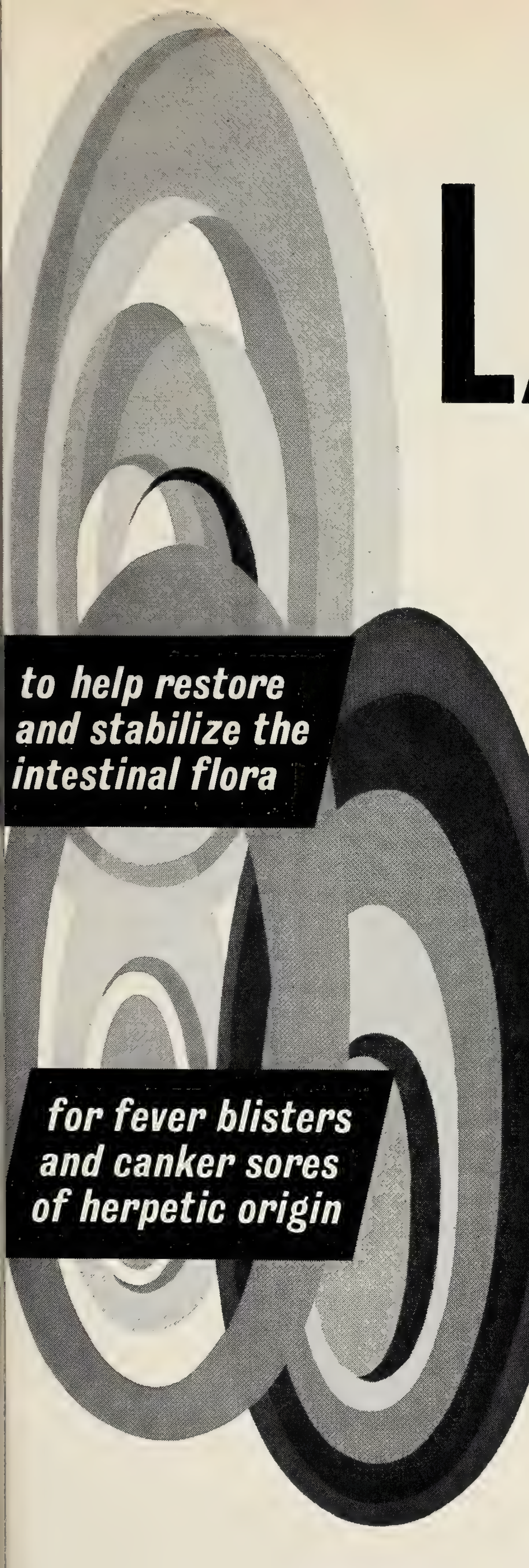
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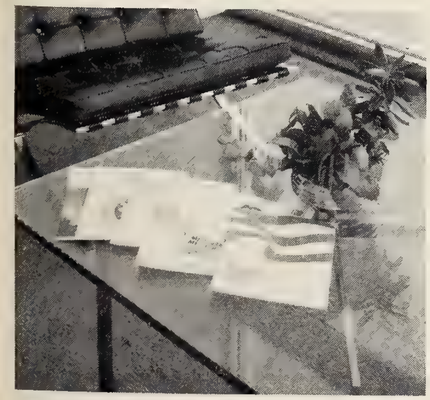
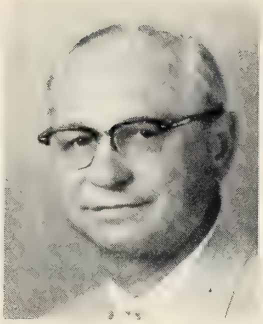
IT'S IN RECEPTION ROOMS





LUTHER R. LEADER, M.D.
Birmingham

the president's message . . .

AN EDITOR SPEAKS

Ideally, every member of MSMS should have heard Jenkin Lloyd Jones, noted editor of the **Tulsa Tribune,** at the Centennial Session. The physicians who did hear him at the "Medicine and Voluntary Health Day" banquet at the Rackham Building applauded his vigorous suggestions to the medical profession.

May I relay some of his comments that especially caught my attention . . .

"The public estimation of the medical profession has, in my opinion, slipped backward . . . while your abilities are now almost universally conceded, your good intentions are coming under increasing question."

* * *

EDITOR JONES then proceeded with these recommendations:

"The local medical society should designate physicians on a rotating schedule to handle emergency calls. Whenever a real emergency fails to get a response, the scars go deep.

"Secondly, the medical profession must be more vigilant than it has been in curbing its own racketeers. In those cases where charges run consistently out of line there should be some very tough talk, for the boodlers are a menace to the whole group. Most medical societies anesthetize their consciences by setting up grievance committees . . . but few patients with any pride ever complain. The silent, but injured patient is dangerous to the future of private medicine.

"I wonder if the medical profession has thrown adequate weight behind schemes for getting hospital costs down. Is there any reason why certain hospitals should not be designated for the treatment of certain relatively rare ailments?

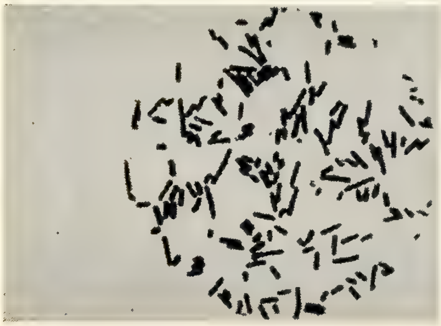
* * *

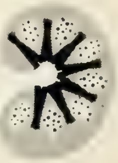
"I WOULD suggest that every legitimate opportunity be used to demonstrate that doctors—private doctors—are seriously concerned with the public welfare. Plain old publicity. Medicine is the only profession I know where outstanding achievement is supposed to be kept a secret from the community in which it has occurred.

"I suggest too that the county medical group concern itself with helping the public come to sane conclusions about local health problems—such as a polluted swimming lake.

"Your genius is conceded. Your techniques are admired. Your research is held in awe. But these things won't save you from the smothering embrace of the welfare state. It is your heart you have to prove."

positive thinking about gram-negatives





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Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

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Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately *25 mg. per pound* of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

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INFORMATION FOR READERS / CONTRIBUTORS:

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1. Address scientific manuscripts to Editor, Michigan Medicine, C. J. Tupper, M.D., 2490 Adare, Ann Arbor, Michigan.
2. Submit original, double-spaced typewritten copy and one carbon copy on letter size (8½ x 11 inch) paper.
3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.
4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.
5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by The Journal. The Journal will pay the first $25 of the engraving bill, and the author shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.
6. References will ordinarily be limited to seven in number. Exceptions may occassionally be made.
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8. Articles should ordinarily be less than four printed pages in length (3000 words).
9. References should conform to *Cumulative Index Medicus*, including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.
10. Specify address to which galley proof should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.
11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.
12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

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NEWS BRIEFS

Thirty-four Michigan surgeons were recently inducted as fellows of the American College of Surgeons at its clinical congress in Atlantic City. The Michigan group included **James E. Kermath, M.D.**, Allen Park; **Edwin G. Meyer, M.D.**, Alma; **Donald R. Kahn, M.D.**, **Robert L. Kerry, M.D.**, Ann Arbor; **John W. Grigg, M.D.**, **Floyd R. Parks, Jr., M.D.**, Bay City; **James T. Mimura, M.D.**, Birmingham; **Paul Gonick, M.D.**, Dearborn; **Abraham Blumer, M.D.**, **Robert G. Borchak, M.D.**, **Bernard Eisenstein, M.D.**, **Raymond V. Jungwirth, M.D.**, **Harvey Y. Lewis, M.D.**, **Andres D. Resto Soto, M.D.**, **Andrew E. Stefani, M.D.**, **Martin B. Trotsky, M.D.**, Detroit; **William E. Siebert, M.D.**, Farmington; **O. Foster Kline, Jr., M.D.**, Flint; **Wallace B. Dorain, M.D.**, **Robert S. Levine, M.D.**, Grand Rapids; **Roscoe V. Stuber, M.D.**, Howell; **John L. Kihm, M.D.**, **Robert C. Buslepp, M.D.**, Jackson; **Robert S. Johnson, M.D.**, **Omero S. Iung, M.D.**, Lansing; **Peter J. Connaughton, M.D.**, Petoskey; **Peter A. Duhamel, M.D.**, Rochester; **John A. Fushman, M.D.**, **William W. Bronson, M.D.**, Royal Oak; **Albert W. Farley, Jr., M.D.**, **E. Malcolm Field, M.D.**, **Hugh L. Sulfridge, M.D.**, Saginaw; **David Burnstine, M.D.**, **Fredrick Weissman, M.D.**, Southfield.

Myron E. Wegman, M.D., dean of University of Michigan School of Public Health, has been elected chairman of the executive board of the American Public Health Association.

S. C. Wiersma, M.D., a physician at Muskegon since 1943, has joined the Department of Physical Medicine and Rehabilitation at the University Hospital, Ann Arbor.

Florine K. Hampton, M.D., is the new deputy public health director of the Wayne County Department of Health. Dr. Hampton formerly served with the Michigan Department of Health where she served for the past two years as medical consultant. Between 1951 and 1960 she was engaged in the private practice of medicine in Portsmouth, Virginia.

Harry L. Riggs, M.D., continues as president of the Pontiac Urban League, serving his second year term as the leader.

Homer Weir, M.D., medical director of Mt. Rainier State Home and Training School, Olympia, Washington, will begin duties February 1 as the superintendent of the Plymouth State Home and Training School. Dr. Weir was formerly director of the Retardation Center, Department of Pediatrics, Baylor University, and director of the Consultation, Diagnostic and Evaluation Center at Rockford, Illinois.

Scott T. Harris, M.D., Ypsilanti, who is serving as acting superintendent, will resume his former position as clinical director.

Charles S. Stevenson, M.D., Wayne State University Department of Obstetrics and Gynecology, has been named director of research for the Ob-Gyn Resident Training Program of Grace Hospital.

Jack C. Westman, M.D., is now Director of the Children's Division of the Department of Psychiatry at the University of Wisconsin Medical School, and also Professor of Psychiatry. He formerly was Associate Professor of Psychiatry at the University of Michigan Medical School and Director of the Outpatient Service at Children's Psychiatric Hospital, a unit of the University of Michigan Medical Center.

The American Medical Association has appointed **D. Ann Sparmacher, R.N.**, as director of its Department of Nursing. Mrs. Sparmacher, whose appointment becomes effective November 1, was formerly executive director of the Chicago Council on Community Nursing. She succeeds **Florence M. Alexander, Ph.D., R.N.**, who has accepted a position on the faculty of the University of Michigan, Ann Arbor.

Otto J. Preston, M.D., has been appointed to the newly created position of national medical director of the Chevrolet Division of the General Motors Corporation. Dr. Preston will direct the medical activities and personnel of all of the Chevrolet medical departments and services.

Dr. Preston received his M.D. from the Loyola University School of Medicine in 1934 and has been associated with the Chevrolet Division since 1937.

The Wayne State University Neurological Center for Cerebrovascular Research has received a grant of $297,472 from the U. S. Public Health Service (USPHS). **John Stirling Meyer, M.D.**, Birmingham, professor and chairman of neurology, will use the funds for general support of the work being done at the center.

Girard Veenschoten, M.D., of Hesperia, has been appointed the new director of the Allegan County Health Department.

Edna M. Jones, M.D., who retired in 1961 after 30 years at Mayberry Sanatorium, Northville, recently received the Bruce H. Douglas Award from the Michigan Thoracic Society.

John P. Cannon, M.D., President of the Wexford County Medical Society, appeared on a WW-TV program at Cadillac to discuss self-medication and drug abuse with Truman Walrod, station director of community affairs; Allan G. Weatherwax, executive director of the Michigan Board of Pharmacy, and Robert C. Johnson, executive secretary of the Michigan State Pharmaceutical Association.

Channing Lipson, M.D., and **Thomas A. Petty, M.D.**, both with the WSU medical school, spoke at the first of four conferences at WSU on "Mental Health in the Great Society." Information about future conferences January 28, February 25 and March 25 may be obtained from WSU College of Education.

Joseph N. Schaeffer, M.D., Director of the Rehabilitation Institute, Detroit, reports that **Jan Nyboer, M.D.**, is now director of research and **Victor Nyboer, M.D.** (no relation) is a staff physiatrist. Dr. Jan Nyboer previously served as Chief of the Division of Cardiovascular Physiology Research at Detroit's Harper Hospital. He will continue to serve as professor in the Department of Physiology and Pharmacology of Wayne State University. Dr. Victor Nyboer, M.D., was in training at the University of Michigan Hospital in the Department of Physical Medicine and Rehabilitation before coming to Detroit.

Three Michigan physicians' aides became Certified Medical Assistants in 1965 under the program sponsored by the American Association of Medical Assistants. **Esther Bartlett**, Detroit, received certification in both the clinical and administrative categories; certified in the administrative classification were **Marilyn Keith**, Ann Arbor, and **Jo Petroelje**, Byron Center.

With the aid of a special legislative appropriation of $300,000, the Michigan Department of Health is launching an all-out effort to prevent convalescing tuberculosis patients from suffering a relapse. State Health Commissioner **Albert E. Heustis, M.D.**, reports the funds will be used to subsidize counties for following-up cases of patients discharged from sanitoriums or hospitals.

The American College of Physicians recently held a regional meeting at Hidden Valley. The meeting was arranged under the direction of **Noyes L. Avery, Jr., M.D.**, Grand Rapids, ACP Governor for Michigan; **Muir Clapper, M.D.**, Detroit, chairman, program committee, and **Richard H. Wunsch, M.D.**, Traverse City, chairman, arrangements committee.

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Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.
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Welcome, New Members!

Faris Azoury, M.D., Detroit Receiving Hospital, Detroit, Michigan

Leandre I. Bautista, M.D., 203 First Security Bank Bldg., Ionia, Michigan 48846

William L. Beauregard, M.D., 1201 David Whitney Bldg., Detroit 26, Michigan

Roger W. Becklund, M.D., 2155 Englewood Dr. S.E., Grand Rapids, Michigan 49506 *(Surgery)*

Claude Benavides, M.D., 25750 W. Outer Drive, Lincoln Park, Michigan *(Surgery)*

James A. Bennett, M.D., 4407 Roemer, Dearborn, Michigan *(General Practice)*

Henri Bernard, M.D., Detroit Receiving Hospital, Detroit, Michigan

Barbara F. Carlson, M.D., St. Joseph Mercy Hospital, Pontiac, Michigan

Jerome D. Davis, M.D., 19075 Middlebelt Rd., Livonia, Michigan *(Ophthalmology)*

Frederick A. Deigert, M.D., 3775 Oakridge Avenue, Comstock Park, Michigan 49321 *(Radiology)*

Mohammad G. Dorostkar, M.D., 27549 W. 6 Mile Rd., Livonia, Michigan *(Anesthesiology)*

Jean C. Elie, M.D., 938 David Whitney Bldg., Detroit 26, Michigan *(Surgery)*

Richard F. Elton, M.D., Detroit Receiving Hospital, Detroit, Michigan

Alfredo G. Fleurquin, M.D., 4930 Big Oak Trail, Birmingham, Michigan 48008 *(Roentgenology-Radiology)*

Jack Ford, M.D., 3063 Williamsburg, Ann Arbor, Michigan *(Obstetrics-Gynecology)*

James P. Gallagher, M.D., 828 Fisher Bldg., Detroit 2, Michigan

Abraham G. Gotman, M.D., 987 E. Jefferson Avenue, Detroit 7, Michigan *(Obstetrics-Gynecology)*

N. Naci Karca, M.D., 6846 Cooley Lake Rd., Union Lake, Michigan 48085 *(Surgery)*

Jack L. Kelley, M.D., 1208 Prospect, Ann Arbor, Michigan *(Surgery)*

Bert J. Korhonen, M.D., 2535 McKee Avenue S.E., Grand Rapids, Michigan 49509 *(Orthopedic Surgery)*

Herbert Krickstein, M.D., 643 Braeside Pl., Ann Arbor, Michigan *(Pathology)*

George E. LaCroix, M.D., 3790 Woodward Avenue, Detroit 2, Michigan

Russell E. Leach, M.D., Drawer 494 Ionia State Hospital, Ionia, Michigan

John L. Loomis, M.D., 236 Visger Rd., River Rouge, Michigan *(Surgery)*

Clyde A. Luck, Jr., M.D., 2401 E. 7 Mile Rd., Detroit 34, Michigan *(Surgery)*

Aaron Lupovitch, M.D., 24661 Kenosha, Oak Park, Michigan 48237 *(Pathology)*

Roy J. McKinney, M.D., 719 New Center Bldg., Detroit, Michigan

Judith L. Meyer, M.D., 1756 Newark Avenue S.E., Grand Rapids, Michigan 49507 *(Obstetrics-Gynecology)*

Scott K. Price, M.D., 3815 Pelham Rd., Dearborn, Michigan

Larry J. Robson, M.D., 1029 San Jose Drive S.E., Grand Rapids, Michigan 49506 *(Surgery)*

Aaron Schneider, M.D., 26505 John R. St., Madison Heights, Michigan 48071

Leonard Schreier, M.D., 18055 Greenfield, Detroit 35, Michigan

Theodore N. Siller, M.D., 18980 Wyoming, Detroit 21, Michigan

Ray C. Smith, Jr., M.D., Allegan, Michigan

Edward Southern, M.D., Allegan, Michigan

Timothy M. Talbott, M.D., 1542 Michigan St. N.E., Apt. C1, Grand Rapids, Michigan 49503 *(Surgery)*

Luis A. Tomatis, M.D., 456 Cherry St. S.E., Grand Rapids, Michigan 49503 *(Cardiovascular Diseases)*

Charles L. Wischman, M.D., 2927 Oakdale Dr., Ann Arbor, Michigan *(Internal Medicine)*

Warren A. Wood, Jr., M.D., 629 Washington Square Plaza, Royal Oak, Michigan 48067 *(Obstetrics-Gynecology)*

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Contraindications: Hyperexcitable and prepsychotic states; patients hypersensitive to meprobamate.

Side Effects: Occasional allergic skin reactions may occur with meprobamate, accompanied by fever, nonthrombocytopenic purpura, angioneurotic edema, hypotension, or bronchial spasm. Drowsiness with or without ataxia and/or alteration in visual accommodation may occur. Effects of alcoholic beverages may be increased by meprobamate. Use with caution in patients with coronary or cardiovascular disease or severe hypertension. Prolonged use may result in dependence. Reactions can occur if drug is not withdrawn gradually.

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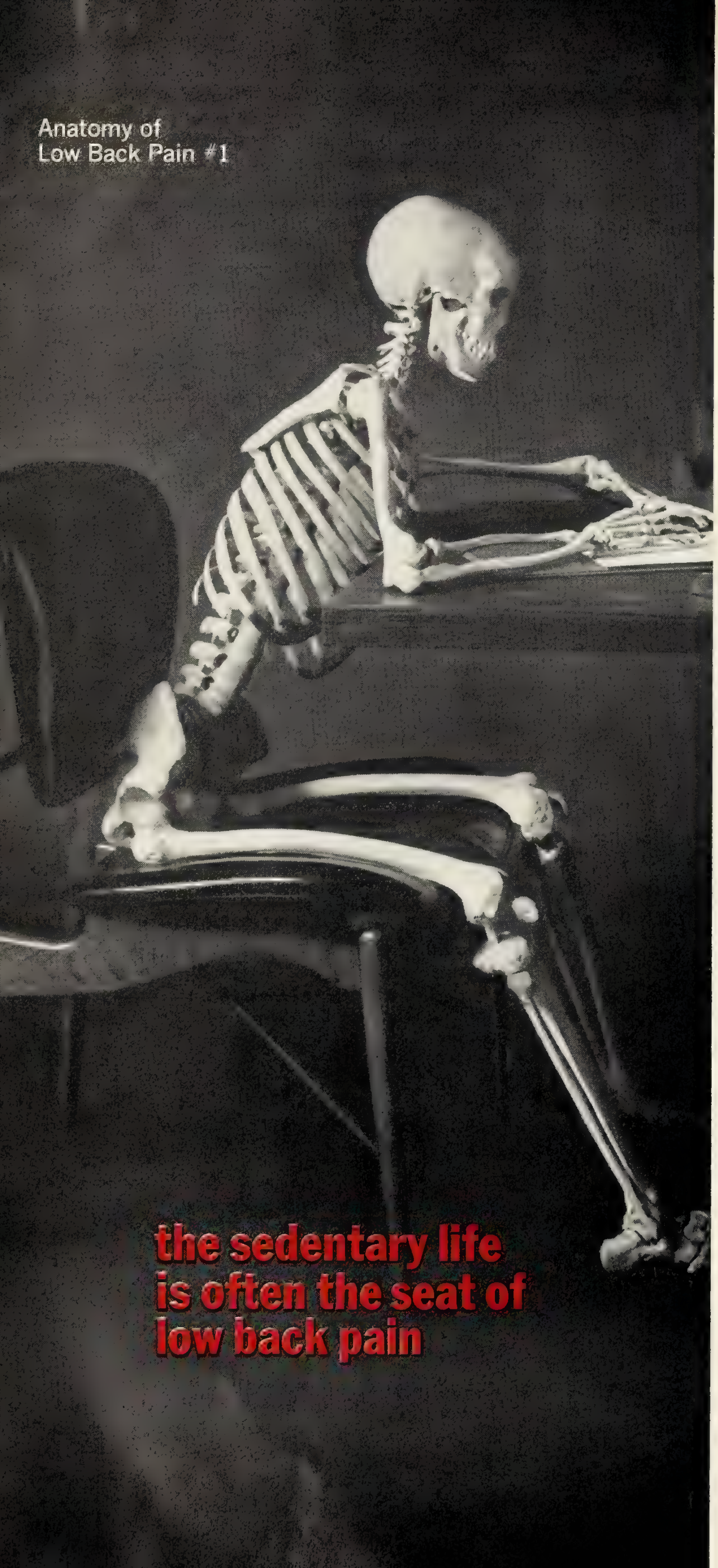

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Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

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PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia, hypochloremic alkalosis and hyponatremia may occur. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Insulin requirements may be altered in diabetes.

WARNINGS: Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease; advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or disfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties.

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IN MEMORIAM

ROBERT A. BURHANS, M.D.

Robert A. Burhans, M.D., 64, Lansing urologist, died October 31.

A resident of the Lansing area since 1912, Doctor Burhans received his degree in medicine from the University of Michigan in 1929. He interned at Grace Hospital in Detroit and took his residency in Herman Kiefer Hospital, also of Detroit. Doctor Burhans practiced in Lansing for 31 years, and was a member of the staffs at Sparrow, St. Lawrence and Ingham Medical hospitals there.

Doctor Burhans was a fellow of the American College of Surgeons, American Board of Urology, American Urological Society and a member of the Michigan Association of the Professions.

During World War II Doctor Burhans served in the Navy Medical Corps for three years.

HARRY J. BUTLER, M.D.

Harry J. Butler, M.D., Highland Park physician, died October 18 in the Ford Convalescent Center of that city. He was 90 years old.

Born in England, Doctor Butler settled in Sanilac County with his parents in 1881. He taught school in Deckerville, Carsonville and Peck before entering the Detroit College of Medicine in 1906. After receiving his medical degree, Doctor Butler practiced in Deckerville until 1917 when he moved to Highland Park.

Doctor Butler was a life member of the Michigan State Medical Society.

Among the survivors is a son, Volney N. Butler, M.D., of Highland Park.

WILLET HERRINGTON, M.D.

Willet Herrington, M.D., first president of the Huron County Medical Society, died October 11. He was 69 years old.

Doctor Herrington was graduated from the University of Pennsylvania Medical School in 1921. His hospital affiliations included Hubbard Memorial in Bad Axe, where Doctor Herrington was in the general practice of medicine with special attention to his specialty in surgery.

Doctor Herrington was a fellow in the American College of Surgeons.

Among the survivors is a son, Kenneth B. Herrington, M.D., also of Bad Axe.

A. JOSEPH HIMMELHOCH, M.D.

A. Joseph Himmelhoch, M.D., 65, Detroit pediatrician, died October 28 at Harper Hospital.

Doctor Himmelhoch, a native of Detroit, was graduated from the University of Michigan and Johns Hopkins University. At the time of his death Doctor Himmelhoch was senior attending physician in pediatrics at Harper, Children's and Sinai Hospitals in Detroit. Doctor Himmelhoch was a diplomate of the American College of Pediatrics.

Two sons, Johnathan M. Himmelhoch, M.D., and S. Ralph Himmelhoch, M.D., are among the survivors.

PAUL IVKOVICH, M.D.

Paul Ivkovich, M.D., 56, Reed City physician, died October 5 in Blodgett Memorial Hospital, Grand Rapids.

Doctor Ivkovich was graduated from Wayne State University School of Medicine in 1935. He interned at Eloise General Hospital, Detroit, later starting his practice in Evart.

Long active in medical society affairs, Doctor Ivkovich was a delegate to the MSMS House of Delegates, Chairman of the Multi-County Component Medical Societies Committee and a member of several Society committees at the time of his death.

Doctor Ivkovich served in World War II from 1941 to 1945 after which he began his medical practice in Reed City.

SOLOMON MEYERS, M.D.

Solomon Meyers, M.D., 68, Detroit diagnostician, died October 15 in Harper Hospital where he had been chief of the Internal Medicine Division for nine years before his retirement in 1963.

Born in Detroit, Doctor Meyers was a graduate of Chicago's Rush Medical College and he studied in Berlin and Vienna. His specialty was diseases of the digestive tract. Doctor Meyers was professor of internal medicine at Wayne State University School of Medicine.

Doctor Meyers had been serving as a consultant at Harper and at Sinai, Detroit General and the Veterans Administration hospitals in Detroit. Formerly he served as vice chief of staff and chief of

(Continued on Page 909)

Announcing

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for control of moderate to severe hypertension

Unique combination produces greater antihypertensive effect with lower doses

Eutron is the combination in a single tablet of 25 mg. Eutonyl (pargyline hydrochloride) and 5 mg. Enduron (methyclothiazide). This combination produces greater therapeutic effect than that of either component used alone. Side effects may be milder, too, as dosages are generally lower. The effective dosage is usually one tablet, once daily. Tablets are scored for greater dosage flexibility.

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In clinical trials, Eutron produced normotension or a significant reduction in blood pressure in eight out of 10 patients studied. The rationale for the product is this: Eutonyl used alone is a potent antihypertensive. Its antihypertensive action is markedly enhanced by Enduron, a potassium-sparing thiazide.[1,2,3] The combination (Eutron) thus produces greater antihypertensive effect with lower dosages of the Eutonyl component, and milder side effects may be seen.

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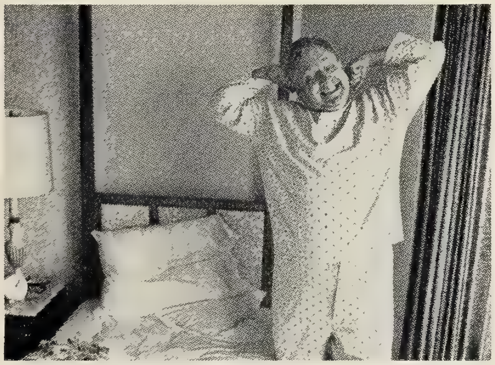
1. Torosdag, S., Schvartz, N., Fletcher, L., Fertig, H., Schwartz, M. S., Quan, R. F. B., and Bryant, J. M., Pargyline Hydrochloride as an Antihypertensive Agent With and Without A Thiazide, Am. J. Cardiol., 12:822, Dec., 1963.
2. Pollack, P. J., Pargyline Hydrochloride and Methyclothiazide Combined In The Treatment of Hypertension, Cur. Thera. Res., 7:10, Jan., 1965.
3. Bryant, J. M. et al., Antihypertensive Properties of Pargyline Hydrochloride, New Non-Hydrazine Monoamine Oxidase Inhibitor Compared with Sulphonamide Diuretics, J.A.M.A., 178; 406, Oct., 1961.

BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.



The average *standing* reduction in clinical trials was 45/22 mm. Hg. Thus the difference between the standing and recumbent readings was only 9/4 mm. Hg.

Significantly lowers blood pressure in all body positions; less likelihood of orthostatic hypotension

In clinical trials, the average reduction in standing blood pressure was 45/22 mm. Hg.; in the sitting position it was 48/20 mm. Hg.; and in the recumbent position, 36/18 mm. Hg.

Because Eutron effectively reduces blood pressure in all body positions, there is reduced likelihood of orthostatic symptoms or hypotension.

This was reflected in the relatively mild character of side effects seen in clinical trials (see below).

Smooth and gradual onset

Onset of antihypertensive action is usually quite smooth. Initial reduction of systolic and diastolic readings is usually seen within a week — maximum reduction in seven to ten days.

Less troublesome side effects may be seen; frequent improvement in "sense of well-being"

Fewer than 1% of patients studied discontinued Eutron therapy because of side effects. This is due in part to the relatively low dosage needed with the combination. Usual recommended dose is one tablet daily—that is, 25 mg. Eutonyl with 5 mg. Enduron. *This is about half the usual therapeutic dose of Eutonyl given alone.* As a consequence side effects may be milder. And, as with Eutonyl given alone, the patient may well note an increased sense of well being. This is in distinct contrast to most other antihypertensive therapy.

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Prescribing information for
EUTRON

INDICATIONS: Eutron (pargyline hydrochloride and methyclothiazide) is indicated in the treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. It is not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

CONTRAINDICATIONS: Eutron is contraindicated in patients with pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained it cannot be recommended for use in patients with malignant hypertension, children (under 12 years of age), or pregnant patients.

The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

WARNINGS: Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of ¼ to ⅕ the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

PRECAUTIONS: When determining the antihypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

Elevated blood urea nitrogen, serum uric acid or blood sugar are possibilities attributable to the methyclothiazide in Eutron. Methyclothiazide may also reduce arterial response to pressor amines. Blood dyscrasias, including thrombocytopemia with purpura, agranulocytosis and aplastic anemia, have been seen with thiazide drugs.

SIDE EFFECTS: The use of pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve. Nocturia has been observed with the combination. If side effects persist, despite symptomatic therapy or reduction of the dose, discontinue the drug.

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staff at Sinai's predecessor, the North End Clinic.

Doctor Meyers was a fellow of the American College of Physicians.

During World War II Doctor Meyers was a medical officer with the Harper Hospital Unit of the Army Medical Corps in Europe and Africa.

WALTER W. OLIVER, M.D.

Walter W. Oliver, M.D., Grand Rapids physician since 1919, died September 21 at Butterworth Hospital. He was 78 years old.

Doctor Oliver, a native of Camden, was graduated from the University of Michigan Medical School in 1914. An honorary member of the Butterworth Hospital medical staff and associate at both Blodgett and St. Mary's Hospitals, Doctor Oliver assisted in organizing and conducting an eye clinic at Butterworth for the Grand Rapids Blind Association.

During World War I Doctor Oliver served as a lieutenant in the Army Medical Corps.

A member of Alpha Tau Omega and Phi Beta Pi fraternities, Doctor Oliver was cited as Conservationist of the Year in 1959.

Doctor Oliver was a Life Member of the American Medical Association and the Michigan State Medical Society.

HAROLD E. OLNEY, M.D.

Harold E. Olney, M.D., 77, physician and surgeon of Leonidas, died October 23 at Three Rivers Hospital. He was the only physician and surgeon serving the towns of Mendon and Leonidas.

Doctor Olney obtained his medical degree from the University of Chicago Medical School in 1916, interned at Passavant Hospital in Chicago, and came to Centreville in 1917.

In 1923 Doctor Olney went to Detroit and there was chief of staff at Deaconess Hospital and on the staff of Jennings Hospital. Doctor Olney moved to Leonidas and built his clinic in 1945, and had since been on the staff of Three Rivers Hospital.

Among the survivors is a granddaughter, a student at the University of Michigan Medical School.

JOSEPH B. RYDZEWSKI, M.D.

Joseph B. Rydzewski, M.D., 74, Detroit general practitioner, died October 25.

Born and educated in Poland, Doctor Rydzewski received his medical degree from the General Medical College in Chicago in 1924. Doctor Rydzewski engaged in the general practice of medicine in Detroit for 40 years.

Doctor Rydzewski was a Life Member of the Michigan State Medical Society.

JACOB SHAPIRO, M.D.

Jacob Shapiro, M.D., 61, Detroit physician, died October 13, at Woman's Hospital.

A native of Cleveland, Doctor Shapiro was a 1929 graduate of the University of Michigan Medical School. He practiced medicine in the Detroit area for 19 years.

Doctor Shapiro's hospital affiliations included Eastside General, North Detroit General and Saratoga General.

During World War II Doctor Shapiro served as a lieutenant colonel in the Army Medical Corps.

Among the survivors is a son, Howard Shapiro, M.D.

GEORGE M. VIRGA, M.D.

George M. Virga, M.D., 52, Royal Oak, died October 18 at William Beaumont Hospital where he was staff physician.

A native of Detroit, Doctor Virga received his medical degree from the University of Michigan Medical School. Doctor Virga was a member of Alpha Omega and Phi Kappa Phi medical fraternities and a diplomate of the American Board of Surgery.

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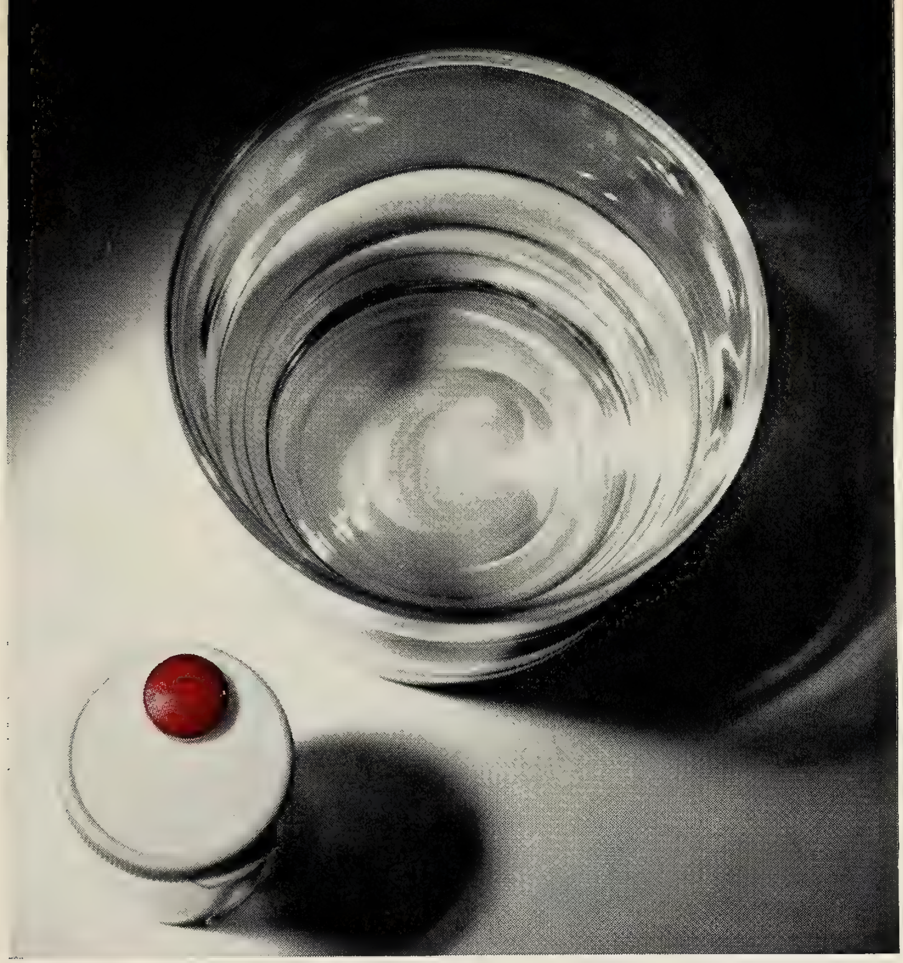

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Tablets: 300 mg of demethylchlortetracycline HCl.

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6555-2355

Legal Responsibilities of Hospital Health Officer Discussed

By Max Karl Newman, M.D.
Detroit

A recent ruling of a New York trial court permitted recovery in a damage suit against the hospital based on the negligence of the admitting physician to permit hospitalization. (Barcia v. Society of New York Hospital, 241 N.Y.S. 2d 3737 (N.Y., June 12, 1963).)

Law and Medicine have been primary forces in the molding of civilization. Law, Civilized Law, attempts to direct the minds and mores of men toward constructive social behavior. Medicine attempts to understand life's processes and wrestles with the body's sometimes mysterious dysfunctions. Law and Medicine may form an uneasy association within a helpful partnership when Law becomes zealously protective of patients. It is essential that the physician and the hospital be adequately informed of the law regarding medico-legal situations if their medical duties are to be carried out with effective confidence.

Increasingly the private type of practice is taking place in nonprofit hospital outpatient departments. This makes it necessary for the referring physician and the medical house officer to be oriented to the legal responsibilities of their positions. When alleged medical negligence (malpractice) occurs, professional liability is now being interpreted by the public into larger verdicts and greater frequency of claims—all resulting in attenuation of the physician-patient relationship. Medical house officers have little if any orientation regarding their medical-legal responsibilities. When a medical decision refuses admission of a patient to the hospital, particularly when the referral of the patient is by the family physician, medical house officers do not yet recognize the potential import of such refusal. The merit of the medical judgment in referring the patient to the hospital in the first place opens another discussion, not dealt with here.

Medical house officers must be considered employees of the hospital. As such, the Law of Tort Liability (wrongdoing) applies to the Medical House Officer *and* the Hospital; but *not* to the referring physician who had requested hospitalization; in legal terminology, *respondeat superior* (the employer) is liable for the torts of his employees, committed in course of their employment. In a limited immunity hospital, the hospital selects the employee (medical house officer). This arrangement implies three things:

1. That its physicians possess the requisite skill, degree of learning, and ability necessary to practice their profession, which others similarly situated ordinarily possess.

2. That the physician exercise reasonable and ordinary care and diligence in the use of his skill in application of his knowledge to the patient's case.

3. That the physician exert his best judgment in the treatment and care of the patient.

Since a recent State Supreme Court ruling in Michigan removes a great deal of the limited immunity, almost all hospitals have taken liability insurance as a means of protection against law suits for patient injury. Even this protection, therefore, permits lawsuit, since this furnished non-trust assets, is subject to legal action for recovery of damages as a result of tortious acts.

Many problems of potential negligence do arise in a hospital environment: falling out of bed, being frightened by a noise or events resulting in opening of an incision, jumping out of a window, burns by hot water bottles, electrical gadgets, injury by leaking roofs and windows, intravenous appliances, poisoning, environmental infections, improper medication, injury from defective equipment. However, if no supervision is given to the Emergency Outpatient Department, *legally,* greater damage of liability exists for the hospital and the medical house officer. Serious bleeding episodes of viscus, incipient coronary thrombosis, diabetic acidosis, severe respiratory infection in children, failure to detect and remove foreign bodies, failure to recognize intestinal obstruction or the acutely involved abdomen, drug reactions from improper tetanus antitoxin, desensitization testing, drug overdosage, opening of the airways and cardiac massage, rapid decompression of bladders of the aged—all are situations requiring medical and legal alertness by the medical house officer.

Finally, it is possible for a hospital to sue the medical officer for malpractice where previous lawsuits against the hospital have been successful. The medical officer, now in practice or residency must face the consequence of malpractice. Good medical practice obviates medico-legal problems.

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"Magazines can select, probe, investigate at length. They can reflect, interpret, quarrel with and applaud. They can identify issues, trends and concerns. Magazines are for people whose minds are at work. They are indeed the light artillery of the intellect."

—William Porter, *School of Journalism, University of Michigan*

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Each capsule contains:

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homatropine methylbromide	1.25 mg.

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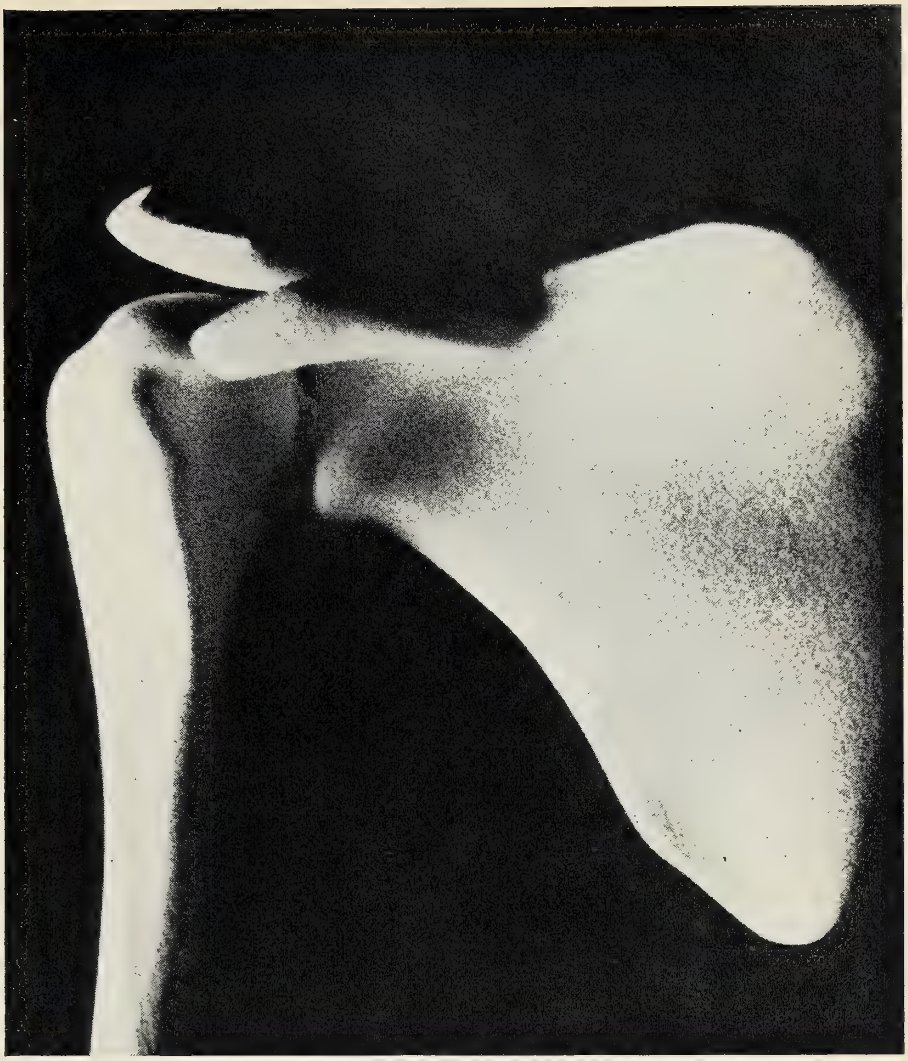

Geigy

Therapeutic Effects

The acute phase of subdeltoid bursitis, tendinitis and associated periarticular inflammation usually responds promptly and dramatically to phenylbutazone. Pain and tenderness may be relieved within 24-48 hours and mobility of the affected arm quickly restored. Full recovery is frequently achieved within 7-10 days so that therapy is generally of short duration. Calcific deposits are not specifically affected by treatment, but their presence does not appear to retard symptomatic improvement.

Phenylbutazone has not replaced physiotherapy, x-ray treatment, or local injections of hydrocortisone in the more chronic conditions, but it may advantageously be combined with these measures.

Contraindications

Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions

Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions

The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage

Initially, give 400 mg. daily (one capsule q.i.d), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. Butazolidin alka contains antacids and an antispasmodic to minimize gastric upset.

Note: The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

Also available:
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Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Side-Effects: Even though Ilosone is the most active oral form of erythromycin, the incidence of side-effects is low. Infrequent cases of drug idiosyncrasy, manifested by a form of intrahepatic cholestatic jaundice, have been reported. There have been no known fatal or definite residual effects. Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of patients as a result of a local stimulating action of Ilosone on the alimentary tract. Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

Dosage: *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled.

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The continued additive risks in repetitive cases where recurring or persistent factors jeopardize patients through successive pregnancies call for continuity of female care which emphasizes preventive medicine starting at an early age. It is likewise important to broaden and intensify obstetrical care and to focus our efforts upon high-risk patients, with a realistic expectation of improving perinatal salvage among vulnerable groups.

Management of the High-Risk Obstetrical Patient

By Robert E. L. Nesbitt, Jr., M.D.*
of Syracuse, N. Y.

The problem of perinatal mortality and the distressing aftermath of the birth process that results in damaged but surviving infants continues to concern all workers in the maternal and child health field.

Interest has been rekindled after a period of relative complacency by the less favorable position of the United States in relation to many other countries.† The sharp decline in these losses observed during the years 1935 to 1945, an era of rapid medical and social progress, began to level off gradually; and during the period 1952 to 1959, perinatal mortality decreased by only 2.8 deaths per 1,000.

Moreover, deaths among newborns during the first 24 hours of life, a group which makes up about 40 per cent of all neonatal losses, have actually increased slightly in recent years.

Demographic Variables

Among the important demographic variables which pertain to perinatal mortality are race, age of mother—birth order distribution, socio-economic status, child spacing and prior fetal loss. Events during the 1950's worsened the position of nonwhite patients relative to whites with respect to deaths in the perinatal period and in early infancy. Compared with mortality rates for early infancy, perinatal mortality shows a larger white-nonwhite differential and greater geographic variation. Fetal death rates for geographic divisions have a wider dispersion around their national average than is the case for neonatal rates.

During the 1950's the age of first marriage continued its downward trend and there was a persistent tendency towards larger families. The net result was that the age of mother—birth order distribution has been more unfavorable for survival of the newborn than in 1950 and represents a small

SCIENTIFIC PAPERS

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*Professor and Chairman, Department of Obstetrics and Gynecology, State University of New York Upstate Medical Center, Syracuse, New York.

†All recent national figures in this report were drawn primarily from official vital statistics records and compiled by Sam Shapiro, Director of Research and Statistics, Health Insurance Plan of Greater New York.

part of the slowdown in the rate of decline of the neonatal death rate.

* * *

WHILE THE PROPORTION of white infants weighing less than 2,500 grams at birth dropped from 7.2 to 6.8 per cent of live births from 1950 to 1959, the proportion among nonwhite births rose from 10.4 to 12.9 per cent. The impact of this factor can be appreciated when it is recognized that among infants weighing 2,500 grams or less at birth, 114 per 1,000 die within four weeks after birth. That rate is to be contrasted with 7.8 per 1,000 for all other infants.

Interaction of birth order and age of mother results in a far greater variation in the rates of low birth weight than is indicated when each of these parameters is considered separately. The gravest risk among these groups occurs in the younger women who have the highest rate of illegitimacy—a problem which has been on the increase in recent years.

For the most part, reductions in perinatal mortality have been most striking among women experiencing random losses from nonrecurrent causes. Unfortunately, there has been little progress in reducing perinatal casualties among vulnerable groups who have previously suffered repetitive losses. The reasons for this lack of progress are not entirely clear; however, certain general defects in obstetrical care are readily apparent.

Discontinuity of medical supervision, inadequate preconceptional workup and treatment, which logically should begin in the prereproductive era, and inappropriate timing of pregnancy in relation to the health status of the mother represent critical deficiencies.

The casualties of the perinatal period, both lethal and sublethal, are concentrated in minority segments of the general population who harbor some persistent or recurring disorder which is responsible for a faulty maternal or nidational environment throughout successive pregnancies. These underlying conditions are common to a broad spectrum of specific types of perinatal casualties which can include early and late fetal deaths, neonatal deaths of either premature or term infants and many sublethal defects, both immediate and remote.

General Health

It is important for all women to be prepared to meet their responsibilities of childbearing and to avail themselves of good prenatal care. A patient should not have to marry and suffer repeated losses before an underlying problem is recognized and appropriate investigations are undertaken.

The obstetrician, who frequently is the physician next to see a young woman after she has been discharged by her pediatrician, should be the one most concerned with the adolescent period — a time when medical care is apt to be fragmentary or nonexistent.

* * *

THE EARLY AGE AT which the first pregnancy often now occurs makes it imperative to detect any endocrine, metabolic, nutritional, emotional or chronic medical problem which might carry over into pregnancy and possibly jeopardize its outcome.

The primary objective of such care should be to institute preventive measures, prepare patients for adulthood and parenthood, offer instruction and counsel in family planning, screen patients for factors inimical to maternal and fetal welfare, offer counselling in genetics as required, institute appropriate treatment where indicated and to arrange for specific consultative services as needed, utilizing the total health resources of the community.

Many clinical conditions acquire significance only during pregnancy. Generative tract dysfunctions, which, of course, include pregnancy inefficiency, may be the first clinical manifestation of a significant disorder far removed from the pelvis and the reproductive end organs. Gestational anemias, bacteriuria, prediabetes and hypothyroid states are classic examples, and it is our policy to screen for these disorders routinely during pregnancy. By the same token, Papanicolaou smears obtained primarily for cancer screening can also be subjected to cytohormonal study to determine the tissue response of the combined action of progesterone and estrogen, which reflects the degree of progestational domination. A poor progesterone effect (high karyopyknotic index) may indicate some defect of placentation and impaired hormonal support of the pregancy before clinical signs and symptoms of trouble appear. More elaborate hormonal studies, such as paired determinations of chorionic gonadotrophin and pregnanediol excretion or estriol excretion in the latter half of pregnancy, may be carried out as necessary to identify the problem and to determine a rational therapy.

* * *

OCCASIONALLY, SOME VASCULAR, adrenal, renal, collagen or other systemic disorder, not hitherto recognized, will come to light during pregnancy when appropriate screening is instituted. Many of the anatomic defects of the cervix or fundus and pathological conditions of the pelvis, some of which may be inimical to fetal welfare, can be discovered at the time of the initial or subsequent examination.

Traditionally, these broad medical services during the preconceptional and prenatal periods have not been the primary responsibility of the obstetrician, who has confined himself largely to the management of pregnancy and the treatment of complications peculiar to the gestational state. This restrictive concept of obstetrical care, which is held currently by many practicing physicians, is the greatest deterrent to progress in achieving better over-all results in the vulnerable group.

The immediate challenge would seem to be to apply more widely what is now known about preventive health measures, to search for new clinical correlates which relate directly or indirectly to perinatal mortality and morbidity, to discover better methods for identifying vulnerable patients, and to concentrate our efforts upon these high-risk individuals.

CHART 1.
Maternal-Child Health Care Index
(Major Factors Considered in Determining the Score)

I-III. Maternal age, race, marital status and parity
IV. Past obstetrical history:
  Abortions; premature birth; fetal death; Neonatal death; combinations; Congenital anomaly; Genetic defects.
  Other defects: Physical, neurological, emotional
V. Medical-obstetrical disorders:
  Systemic illnesses, acute and chronic
  Infections: Urinary tract, syphilis, pneumonia
  Diabetes, HCVD, nephritis, heart disease
  Prior abruptio placenta; isoimmunization
VI. Nutritional survey; protein intake; anemia
VII. Endocrine disorders; menstrual dysfunction; infertility
VIII. Generative tract pathology, anomalies, prior surgery, contracted pelvis
IX-X. Emotional, social and economic surveys

CHART 2.
Maternal-Child Health Care Index
(Ten Categories)

Index is based on a perfect score of 100
Low-Risk Patient: Index Score, greater than 70
High-Risk Patient: Index Score, 70 or less
  Latter Patients Require:
    Intensive Work-Up and Supervision
    Hospitalization as Required
    Referral to Special Clinic
    Adequate Staffing, Equipment, and Laboratory Facilities

CHART 3.
Maternal-Child Health Care Index
Characteristics of Low-Risk Patient: Score of 100

White, married, gravida 2, 3 or 4, age 20 to 29
Normal past obstetrical history
  Term pregnancies, normal infants
  No prior obstetrical complications
Normal past medical history
Well nourished, normal diet, normal hgb.
Normal menstrual history
Short conception effort time
No clinical or laboratory evidence of endocrinopathy
Normal pelvic organs; Absence of pelvic disease
  Normal pelvis; Normal vaginal deliveries
Normal emotional stability and maturity
  Normal family relationships
  Early registration; Preconceptual Care
Adequate private income; Adequate education
  Patient is homemaker; good mother
  Nice home; good neighborhood

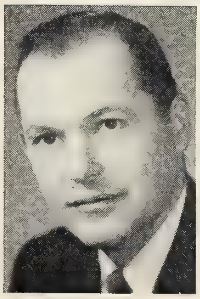
IN ATTEMPTING TO CHARACTERIZE the vulnerable groups who deserve a continuity of intensive care, several interrelated factors bear especial note.

Among these, the following clinical correlates seem to be associated with pregnancy inefficiency: young primigravidas, particularly those who are unwed; advanced maternal age; low socio-economic status; strenuous work outside the home; gynecological dysfunctions and endocrine imbalance; poor nutrition and anemia; chronic debility; prolonged initial conception-effort time; long intervals between pregnancies; prior perinatal casualties; repetitive pregnancies in quick succession, especially after a perinatal loss; hereditary genetic defects; hypertensive cardiovascular and renal disorders; metabolic diseases; anatomic defects of the fundus and/or cervix; pathological conditions of the pelvic organs; and other conditions which compromise the utero-placental-fetal interrelations.

From this long list it is possible to formulate a Maternal and Child Health Index to categorize patients according to the relative risks involved in childhood (Charts 1, 2, 3, 4). Although the clinical correlates taken into account are necessarily incomplete and somewhat arbitrary, the use of an index of this type helps to identify individuals who have need of intensive workup and specialized care. Ideally, these investigations should be carried out in the nonpregnant state and the subsequent pregnancy is undertaken only after appropriate corrective therapies are instituted.

Preconception Clinic

The functions of a preconception clinic and the diagnostic workups involved are similar to those of conventional endocrine-metabolic and infertility clinics, although the referral pattern is broader. The primary problems to be investigated may involve any one or a combination of endocrine and metabolic disorders, emotional disturbances, genetic aberrations, immunological incompatibilities, foci of infection, particularly of the urinary tract, and vascular diseases, all of which may interfere with proper growth and development of the embryo and chorion or with the adaptative mechanisms and environmental accommodations of the conceptus. If the patient has aborted well-formed



The Author
ROBERT E. L.
NESBITT, JR., M.D.

fetuses (Carnegie Types VI or VII), the likelihood of other etiological factors should be considered. These may include systemic diseases, anatomic defects of the generative tract, such as congenital anomalies of the uterus or cervical incompetence, and pelvic pathological conditions involving the reproductive organs, some of which are amenable to surgical correction to improve the childbearing potential.

In selected cases it may be advisable to utilize the simple diagnostic tests now available to detect antibodies against Listeria monocytogenes, a pathogenic organism which produces granulomatous lesions *in utero* capable of producing abortion and fetal death.

* * *

I SHOULD RE-EMPHASIZE the importance of evaluating the personality, stresses, marital dishar-

CHART 4*

Maternal-Child Health Care Index

I. Maternal Age

Under 15: —20 points
15-19: —10
20-29: — 0
30-34: — 5
35-39: —10
40 or More: —20

II. Race and Marital Status

White, Married: — 0 points
White, Single: —10
Negro, Married: — 5
Negro, Single: —10
Other, Married: — 5
Other, Single: —10

III. Parity

0: —10 points
1-3: — 0
4-7: — 5
8 or More: —10

IV. Past Obstetrical History

Abortions
One: —5 points
Two: —10 to —20
3+: —30

Premature Birth
One: —10 points
2+: —20 to —30

Fetal Death
One: —10 points
(Erythroblastotic —30)
2+: —20 to —30

Neonatal Death
One: —10 points
2+: —20 to —30

Any Combination of Above: —20 to —30

Congenital Anomaly
One: —10 points
2+: —20 to —30

Other Defects
Physical: —5 to —10
Neurological: —10 to —20
Emotional: —5 to —10

Genetic Defect
One: —10 to —20 points
2+: —30

V. (A) Medical-Obstetrical Disorders

Systemic Illnesses
Acute, Mild: 0 to —10 points
Acute, Serious: —10 to —30
Chronic, Non-debilitating: —5 to —10
Chronic, Debilitating: —20 to —30

Specific Infections
Urinary Tract
Acute: —5 to —10 points
Recurrent or Chronic: —20 to—30

Syphilis
Partially Treated: —10 points
Untreated: —20
At Term: —30

Pneumonia: Grade —10 to —30
Other: Grade 0 to —20

V. (B) Medical-Obstetrical Disorders

Diabetes (or large fetuses, hydramnios) or history of glycosuria
Prediabetes: Grade —20 points
Clinical diabetes: —30

Hypertensive Cardiovascular Disease
Mild: —10 to —20 points
Severe: —30 points
Recurrent Toxemia: —10 points

Nephritis: —30 points

Heart Disease: without failure or symptoms
Class I: —10
Class II: —10 to —20
Class III or IV: —30
History prior failure: —30

V. (C) Medical-Obstetrical Disorders

Prior Abruptio Placenta
One: —10 to —20 points
(high score if prior to 37th week)
Two: —30

Isoimmunization Problems
Rh Neg., Non-Sensitized: —10
(after 1st pregnancy or after transfusion with Rh positive blood)
Rh Neg., Sensitized: —30 points
Prior infant requiring exchange transfusion: —30
Prior ABO Incompatibility: —20

VI. Nutritional Survey

Appears Malnourished: —20 to —30
Markedly Obese: —30
Severe Weight Loss: —30
Recent Weight Loss more than 10 lbs.: 0 to —10
Inadequate Diet by History:
Protein intake, 50-70 Gms: —10 to —20
Protein intake, less than 50 Gms: —30

Anemia
Hgb., 10-11 Gms: —5 points
Hgb., 9-10 Gms: —10
Hgb., less than 9 Gms: —20 to —30
(depending upon type and severity)

VII. Endocrine Disorders

Pituitary: —30*
Adrenal: —30*
Thyroid: —30*
*If based on laboratory evidence of malfunction

Ovary:
History of Recurrent Menstrual Dysfunction:
—10 to —20 points

Prolonged Infertility
Primary Sterility prior to Current Pregnancy
1-2 Years: —5 to —10 points
2 Years +: —10 to —30

Long Intervals between Pregnancies
2-5 Years: —5 to —10 points
5 Years +: —10 to —30

Charts 5-11.

*Credit: Nesbitt, R. E. L., Jr. Proceedings, Bi-Regional Institute on Maternity Care-Primary Prevention, University of California School of Public Health at Berkeley, pp. 22-28 (June 21-25) 1964.

mony and other psychological problems present in the family. A reassuring, confident attitude, which provides the emotional support so many of these patients need, would seem to be an indispensable part of the medical program. Obstetrical supervision has to be judged deficient if emotional as well as physical handicaps are not recognized as being of great importance in influencing not only the general health status, family planning, potential for future pregnancies and social adjustments but also the type and intensity of patient care to be administered preconceptionally and prenatally.

I have touched herein upon some of the principles involved in expanded obstetrical care which emphasize preventive medicine and intensified concentration upon vulnerable groups. These comments should suffice to point up the complexities of such care and to stress the need for broadly educated physicians in this field of endeavor. The operational ground rules and specific methods of investigation will vary from one clinic to another but the approach is generally applicable.

CHART 4 (Continued)

VIII. (A) Problems of Generative Tract

(Depends upon exam as well as history)

Prior Fetal Malpresentations: —10 to —30 points

Cervical Amputation: —10 to —30
(according to degree)

Prior Cesarean Section: —30 points

Prior Uterine Surgery, other type: —10 to —30
(based on entry into cavity)

Cervical Incompetence: —30 (if associated with recurrent second trimester abortions)

Uterine Anomaly: —10 to —30 (depending upon type)

VIII. (B) Problems of Generative Tract

Uterine Myomata: —5 to —30 points
Myomata larger than orange: —20 points
Submucous type: —30 points

Pelvic Disease: Grade —5 to —30
Ovarian Cysts, less than 6 cm.: —5 to —10
Ovarian Cysts, more than 6 cm.: — 20 to —30
(depending upon type and size)
Endometriosis: —5 to —10 (depending upon extent)

Contracted Pelvis
Borderline Measurements: —10 to —20
Any Contracted Plane: —30

Other: Grade 0 to —30 (according to significance)

IX. Emotional Survey

Grade 0 to —20 based on:

- Fears, attitudes, biases, hostilities, motivations and behavioral patterns
- Prior pregnancies without supervision
- Time of registration
- Standard of child care and responsibilities
- Family unit, marital relationship
- History of psychiatric illness in family

X. Social and Economic Survey

Grade 0 to —10 based on:

Employment—
Husband, patient, children

Annual income adequacy and stability
Public assistance

Education—
Husband, patient, children

Housing—
Location, quality, facilities
Neighborhood environment

Life Cycle Clinic

At the State University of New York Upstate Medical Center in Syracuse, a "Life Cycle Clinic" has been established to provide continuous supervision of females of all ages from the adolescent period through the reproductive years and to deal with the special problems of the vulnerable groups. From the latter I have selected for critical review 162 random patients to illustrate the value as well as the limitations of a broadly-based aggressive program in minimizing perinatal wastage among vulnerable groups. I have every reason to believe that this sample is representative of the clinical material accepted generally for intensive study. I should point out, however, in our area many patients are still being referred to us already pregnant and presenting with serious complaints; hence, our over-all results are not as satisfactory as they might have been if this were not the case.

* * *

REVIEW OF THIS random sample of 162 vulnerable patients revealed that 88 had had previous abortions (of whom 25 were habitual aborters); 35 had had previous perinatal deaths (viable fetuses only, 21 cases; abortions plus loss of viable fetuses, 14 cases); four were registered because of prior premature births; four had experienced a prolonged interval between pregnancies; nine were threatening to abort; and 22 were complicated by some serious medical-obstetrical disorder (Chart 5).

The perinatal mortality rate in this vulnerable

CHART 5*.
Endocrine Study Cases
Indications for Intensive Care (162 Cases)

Significant Past Obstetrical History		
Habitual Abortion (3 or more)		25
Primary	9	
Secondary	16	
Previous Abortions (less than 3)		63
One Abortion	46	
Two Abortions	17	
Previous Perinatal Deaths		35
Viable fetuses only	21	
Abortions plus viable fetuses	14	
Previous Premature Births		4
Complications in Current Pregnancy		
Threatened Abortion Only		9
Serious Medical-Obstetrical Disorder		20
Prolonged Conception Effort Time		4
Other		2

group of patients was 27.6 per cent (Chart 6). Abortion represented the most common outcome (19.1 per cent), while loss of premature infants (8.0 per cent) and of term infants (0.6 per cent) was substantially less. Although these losses among closely supervised patients seem high, a number of independent investigations involving very different populations have estimated the magnitude of the perinatal loss problem as being between 20 and 25 per cent of all pregnancies.

When abortion threatened during the first trimester, as it did in 71 of the 162 cases, the salvage rates were appreciably diminished. There were 36 losses (31 abortions and five deaths among premature infants), representing a 50.7 per cent perinatal death rate (Chart 7).

The poorest salvage rates were encountered in the primary habitual aborter (56.0 per cent) and among patients who had experienced one or more losses of a viable fetus in addition to one or more abortions (57.1 per cent) (Chart 8).

Survival rates among secondary habitual aborters (74.0 per cent) were considerably greater than those of the primary type (41.0 per cent). There was a fairly good salvage rate among women who had experienced only one or two previous abortions (81.0 per cent). The salvage rate among 21 patients who had lost one or more prior viable fetuses was 71.4 per cent.

In reviewing these patients, it was discovered that 140 couples had been studied intensively preconceptionally and supervised closely from an early stage of pregnancy. The impact of preconceptional care in these cases can be appreciated by the dramatic improvement in perinatal salvage after appropriate medical care. Prior to therapy, these 140 women had undertaken 472 pregnancies and in only 14 per cent was the outcome successful.

This distressing record is contrasted with a 72 per cent salvage rate following preconceptional workup, appropriate treatment and intensive care during pregnancy.

* * *

A DISTURBANCE OF hormone excretion was an almost universal finding among the 31 patients who aborted (93.5 per cent), and the incidence was very high among those whose pregnancies terminated prematurely (82.6 per cent) (Chart 9). The primary derangements in these groups were low or falling excretion of urinary chorionic gonadotrophin and pregnanediol levels or low pregnanediol excretion as the sole defect. Endocrine patterns noted among women who had threatened to abort in the first trimester bore a direct relationship to pregnancy outcome. Among 71 women who had threatened to abort, the incidence of urinary hormonal defects was 31.4 per cent when the infant survived, contrasted with 88.9 per cent when the pregnancy resulted in the death of the fetus

CHART 6.

Endocrine Study Cases

Distribution of Cases by Pregnancy Outcome

Abortion		31
First Trimester	24	
Second Trimester	7	
Premature Birth		23
Survived (43.5%)	10	
Fetal Death	11	
Neonatal Death	2	
Term Birth		108
Survived (99.07%)	107	
Fetal Death	1	
Perinatal Loss (162 Cases): 27.6%		
Abortion—19.1%		
Premature—8.0%		
Term—0.6%		

CHART 7.

Endocrine Study Cases

Outcome When Abortion Threatened (71 Cases)

Aborted		31 Cases (43.7%)
First Trimester	24	
Second Trimester	7	
Premature Birth		11 Cases (15.5%)
Survived	6	
Term Birth		29 Cases (40.8%)
Survived	29	
Perinatal Loss		36 Cases (50.7%)
Abortion	31	
Premature	5	

CHART 8.

Endocrine Study Cases

Salvage Rates According to Past Obstetrical History

Habitual Abortion (25 Cases)		56.0%
Previous Abortions (<3) (63 Cases)		81.0%
One Abortion (46 Cases)	80.4%	
Two Abortions (17 Cases)	82.4%	
Previous Perinatal Deaths (35 Cases)		65.7%
Viable Fetuses only (21 Cases)	71.4%	
Plus Abortions (14 Cases)	57.1%	
Previous Premature Births (4 Cases)		75.0%
Complications, Current Preg. only (39 Cases)		74.1%
Threatened Abortion only (9 Cases)	66.7%	
Medical-Obstetrical Disorders (39 Cases)	75.0%	
Other (6 Cases)	83.3%	
TOTAL CASES (162)	72.4%	

CHART 9.

Endocrine Study Cases

Comparison of Endocrine Patterns and Pregnancy Outcome

Type of Defect	Aborted	Premature Birth	Term Birth	Totals
Low or Falling Pregnanediol	9	12	37	58
Low or Falling CG	2	—	1	3
Low CG and Pregnanediol	18	7	—	25
Rising CG, Falling Pregnanediol	—	—	10	10
Rising CG, Normal Pregnanediol	—	—	7	7
NONE	2	4	53	59
TOTAL CASES	31	23	108	162
Percent Defective	93.5%	82.6%	50.9%	63.6%

CHART 10.
Endocrine Study Cases
Pregnancy Outcome According to Endocrine Patterns in Cases of Threatened Abortion

Type of Defect	Aborted	Premature Birth Survived	Premature Birth Dead	Term Birth	TOTALS No.	TOTALS Survived	TOTALS Dead
Low or Falling Pregnanediol	9	1	1	6	17	7	10
Low or Falling CG	2	—	—	1	3	1	2
Low CG and Pregnanediol	18	—	2	—	20	—	20
Rising CG, Falling Pregnanediol	—	1	—	2	3	3	—
Rising CG, Normal Pregnanediol	—	—	—	—	—	—	—
NONE	2	4	2	20	28	24	4
TOTAL CASES	31	6	5	29	71	35	36
Percent Defective	93.5	33.3	60.0	31.0	60.6	31.4	88.9

CHART 11.
Endocrine Study Cases
Endocrine Patterns in Term Pregnancies by Clinical Condition

Type of Defect	Normal Controls	Normal Previous Losses	Erythroblastosis	Toxemia	Diabetes	Anatomic Defect	Threatened Abortion	Other*
Low or Falling Pregnanediol	—	8	9	3	2	1	6	8
Low or Falling CG	—	—	—	—	—	—	1	—
Low CG and Pregnanediol	—	—	—	—	—	—	—	—
Rising CG, Falling Pregnanediol	—	1	3**	1	1	—	—	4
Rising CG, Normal Pregnanediol	—	2	2	2	—	—	—	1
NONE	75	19	1	1	2	4	20	6
TOTAL CASES	75	30	15	7	5	5	27	19
Percent Defective	00.0	36.7	93.3	85.7	60.0	20.0	25.9	68.4

*Includes: Postmaturity (2 Cases), Placenta Previa (2 Cases), Abruptio Placenta (3 Cases), Hypothyroidism (3 Cases), Addison's Disease (3 Cases), Heart Disease (2 Cases), Prediabetes (1 Case), Phlebitis (1 Case), Anemia (1 Case), and Excision of Corpus Luteum at 10th gestational week (1 Case).

**The one fetal death in this series appears in this category; two in this category threatened to abort.

(Chart 10). It should be mentioned that the findings in the colpocytogram yielded similar results and achieved the same general prognostic significance.

Some women who threaten to abort will do so in the presence of an abnormal smear but, usually, if pregnancy proceeds and symptoms disappear, the colpocytogram reverts to normal, either spontaneously or in response to exogenous steroid therapy, and from the beginning a normal chorionic gonadotrophin titer is observed. When the titer is low, it connotes placental deterioration, and the outlook for the pregnancy is grave, regardless of the type of therapy. Women who terminate their pregnancy prematurely have a mean daily excretion of chorionic gonadotrophin which lags behind that of normal patients and the peak is well below expected levels. Pregnanediol excretion begins to tail off noticeably at about the fifth month, and the pattern does not follow the steep curve encountered normally in the latter half of pregnancy.

* * *

IN CASES TERMINATING in abortion, the chorionic gonadotrophin peak is still lower, and the elevated levels diminish at a much faster rate, often reaching a very low titer or even a negative response before expulsion of the fetus. Pregnanediol excretion is also quite low and little rise is noted during ensuing weeks. Only in the case of irreversible placental deterioration is all hope for the preservation of pregnancy lost, and this judgment can be made only after serial hormonal or cytohormonal determinations are evaluated in relation to the clinical situation.

These studies indicate that progesterone is a factor, either as cause or effect, in many abortions and premature births. A defective corpus luteum which fails to give rise in the uterus to a good environment for implantation and early growth of the trophoblast severely jeopardize pregnancy outcome. Defective trophoblasts fail to elaborate sufficient chorionic gonadotrophin to prolong the function of the corpus luteum and to sustain its production of estrogen and progesterone, which, in turn, diminishes uterine vascularity and endometrial support.

Preconceptional workup is required, since a deficiency of ovarian steroid production and of uterine development may be purely a secondary manifestation of defective endocrine systems upon which the ovary depends for its stimulation and support.

* * *

SERIAL URINARY ESTRIOL determinations are useful in evaluating patients who are likely candidates for placental deterioration. In one fetal death at term and in seven premature fetal deaths out of a total of 12 intra-uterine deaths after the period of viability, the 24-hour urinary excretion of estriol showed that a critical level of 3,000 μg or below had been reached in each instance. These deaths occurred in conjunction with severe hypertensive toxemia, and upon examination of the placenta there was evidence of syncytial degeneration, thinning, loss of basophilia, deterioration of nuclei and endarteritis, ischemic necrosis and fibrosis of many terminal villi.

In several of these cases a rise in urinary excretion of chorionic gonadotrophin, presumably related to a proliferation of cytotrophoblast in the placenta, was noted as a concomitant of a falling estriol and pregnanediol excretion pattern.

The fact that 50.9 per cent of the women who succeeded in carrying their pregnancies to term presented an abnormal hormonal pattern in some degree points up the fact that 72 per cent of all these patients had some recognizable medical, nutritional, emotional, metabolic, endocrinological, anatomical or pathological problem. The presence of a variety of obstetrical conditions resulted in a high incidence of deviations in hormonal excretion, primarily those associated with alterations in placental morphology and function. These complications included toxemia (six of seven cases), diabetes (three of five cases), and Rh iso-immunization (14 of 15 cases). (Chart 11). When only an anatomic dect was found in these vulnerable women, the incidence of endocrine defects was low (seven of 27 cases).

* * *

IN CONCLUSION, IT is appropriate to take some pride in the substantial reduction in recent decades in random perinatal deaths as well as in certain conditions complicating pregnancy where disproportionate perinatal wastage has been the rule. However, the continued additive risks in repetitive cases where recurring or persistent factors jeopardize patients through successive pregnancies call for continuity of female care which emphasizes preventive medicine starting at an early age.

Better means of identifying vulnerable groups and of detecting trouble before there is clinical evidence of a threatened pregnancy are badly needed. If it can be established through appropriate testing that there is a reversible stage of placental deterioration which can be corrected by timely therapy, a significant breakthrough in preventive medicine will have been achieved.

It should be emphasized, however, that medicine is a pragmatic science and that it is possible even now to broaden and intensify obstetrical care and to focus our efforts upon high-risk patients with a realistic expectation of improving perinatal salvage.

MSMS Cooperates in Poster For Schools on First Aid

An attractive reference poster of "First Aid and Emergency Procedures in Schools" has been sent to all the Michigan school officials.

It was developed by the Michigan Department of Health and the Michigan Department of Public Instruction and approved by the Michigan State Medical Society Child Welfare Committee, the Michigan Chapter of the American Academy of Pediatrics and the Michigan Health Officers Association.

The poster covers such matters as Bleeding and Shock, Heat Stroke, Stings and Poisons, Burns and Frostbite, etc.

Explain Dow-U-M Experiments

Experiments with an "artificial kidney" made from plastic capillary tubes were described in a paper by scientists of The Dow Chemical Company and the University of Michigan at the recent Urological Research Forum in New Orleans. The authors of the article successfully accomplished hemodialysis in dogs with a unit made from cellulose triacetate capillaries. Each unit consisted of a bundle of 1,000 capillaries, 6 centimeters long. The inside diameter of the capillaries was 90 microns, and the wall thickness was 20 microns. The membrane surface area of the device was 170 square centimeters with an internal volume of 0.3 milliliters. Each bundle was sealed in a glass jacket fitted with a dialysate inlet and outlet.

Congenital Thrombocytopenic Purpura Due to Intrauterine Rubella Infection

By
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The association of congenital thrombocytopenic purpura (CTP) with a history of rueblla infection in early pregnancy or with other malformations characteristic of the rubella syndrome has been previously described.[1,2] Alford, Neva and Weller[3] recently reported three cases of rubella malformations associated with CTP in which rubella virus could be isolated for periods of time up to 18 weeks of age, thus providing virological confirmation of the etiology. Similar findings have been noted in other laboratories.[4,5]

It is the purpose of this report to present a patient with CTP who had no other obvious malformations, but from whom rubella virus could be repeatedly isolated. The use of new virological and serological techniques and the implications of the protracted persistence of virus excretion seem worthy of comment.

CASE REPORT

Baby J.T. was born November 28, 1964, after a 38-week gestation, complicated at approximately the eighth week by a generalized macular rash of four days' duration. Eye discomfort and posterior cervical lymphadenopathy were also present. Because of the confluency of the exanthem in face and extremities the diagnosis of rubella was doubted and, in fact, since on the first day of illness the mother could have been exposed to rubella, gamma globulin was administered. With the exception of aspirin no other medications were taken during pregnancy.

Uneventful labor and delivery resulted in the birth of a male infant weighing 5 lbs 10 oz. His general condition was good but a generalized purpuric rash and enlargement of the liver and spleen to the iliac crest resulted in his transfer to the University of Michigan Medical Center at the age of four days. At this time his weight was 5 lbs 7½ oz, length 42 cm and head circumference 32.5 cm. Physical examination failed to reveal any abnormalities other than those described above. The purpuric lesions slowly faded during his 12 days in the hospital, but the liver and spleen decreased little, if any, in size.

At 7½ weeks of age he weighed 9 lbs, 4½ oz, his length was 53 cm and head circumference 37.6 cm. The skin was clear but the liver and spleen were still palpable at the level of the umbilicus. He was active and alert, could lift his head in the prone position and smiled responsively. Neurological and ophthalmological examinations were normal, with no evidence of glaucoma, cataracts or chorioretinitis. The infant reacted to loud noise with a faint startling response.

A grade I systolic murmur, thought to be functional in nature, was heard at the apex and left sternal border. Heart rhythm and sounds as well as blood pressures and peripheral pulses were within normal limits. Radiological examination of the chest and abdomen at one week of age, and of chest and long bones at eight weeks, failed to reveal any abnormalities other than hepatosplenomegaly.

LABORATORY EXAMINATIONS

The values of peripheral blood elements are recorded in Table I. Bone marrow aspiration initially yielded a hypocellular, poor sample. However, the marrow elements present revealed normal matura-

ABSTRACT: Many babies affected by intrauterine rubella infection continue to excrete virus after birth. This has permitted the recognition of syndromes such as congenital purpura and severe jaundice of the newborn, not ordinarily attributed to rubella virus. The case presented, one of several under study, examplifies the first such condition. The epidemiological implications of protracted virus excretion are discussed.

From the departments of pediatrics and epidemiology, University of Michigan, Ann Arbor, Michigan, and U.S.A.F. Hospital, Wurtsmith A.F.B., Michigan.

This investigation was conducted under the auspices of the Commission on Influenza, Armed Forces Epidemiological Board and was supported in part by the Office of The Surgeon General, U.S. Army, Washington, D. C., and in part by U.S.P.H.S. General Research Support Program.

The technical assistance of Mrs. Margaret Jakobowitz is gratefully acknowledged.

TABLE I.

Peripheral Blood Counts

Days of Life	0	5	9	16	52
Hemoglobin, gms%	17.2	20.6	18.1	16.4	13.4
WBC/cu. mm.	19,100	13,400	11,900	10,500	27,500
Differential					
Seg. Neutrophils	41	36	23	20	15
Bands	5	16	8	4	5
Metamyelocytes		8	3	3	1
Myelocytes		5	6	8	1
Progranulocytes		4	1	2	1
Blasts					1
Lymphocytes	52	12	46	50	52
Eosinophils		8	8	9	7
Basophils		2		1	
Mono-	2	9	5	3	17
Normoblasts/100 WBC's	6	2	3	0	9
Platelets/cu. mm.		26,000	34,000	68,000	178,000

tion form in the granulocytic and erythrocytic series. At seven weeks of age only a few intact megakaryocytes were observed although many platelets were present: granulopoiesis and erythropoiesis were normal.

VIROLOGICAL AND SEROLOGICAL STUDIES

An agent, identified as rubella virus, was isolated from several of the specimens obtained at six days and seven weeks of age. All isolations were carried out in LLC-MK2 cells (a continuous rhesus monkey kidney cell line). The techniques employed have been previously described[6] and the only modification consisted in the use of media 199 (with 0.12 gm % sodium bicarbonate and 1% horse serum) both for the growth and maintenance of the cultures. Urine specimens were diluted with equal volumes of tissue culture media, neutralized with sodium hydroxide and inoculated as 1 ml aliquots which, after an adsorption period of two to four hours, were replaced with fresh media.

The presence of rubella virus in tissue cultures was recognized by the characteristic cytopathogenic changes it causes in LLC-MK2 cells[7] as well as by its intereference with growth of ECHO 11 virus.[8] Both effects were present in the first as well as in subsequent passages. Serological identification of one of the urine isolates was performed by indirect fluorescent staining of cells from the third tissue culture passage with a 1:16 dilution of paired acute and convalescent human sera. Control tissue culture passage, carried out under identical conditions to the infected one, failed to show the obvious cytoplasmic fluorescence seen in infected cells, stained with convalescent serum. Infected cells stained with acute serum did not show specific staining.

Antibody titers were determined by the indirect immunofluorescent assay described by Brown et al.[9]

A summary of these studies is presented in Table II. Virus was present in urine and upper respiratory secretions both at the age of six days and seven weeks. At six days rubella virus was also recovered from a rectal swab but at seven weeks the stool specimen contained an enterovirus which caused rapid death of the cultures. This isolate has not been further characterized as yet but it was of interest that, in tissue culture, rubella virus interferes with its growth.

No isolation was obtained from the serum, which may be due to the antibody content, but virus was recovered from the bone marrow sample at seven weeks suggesting that its concentration in this tissue was sufficient to circumvent the circulating antibody present.

Examination of the urinary sediment for inclusion bearing cells as well as culture of the urine in monolayers of human fibroblasts failed to give evidence of cytomegalovirus infection.

DISCUSSION

Clinically this baby presented with a thrombocytopenic purpura and hepatosplenomegaly which were noticed at birth. The skin lesions slowly faded during the first three weeks of life. The platelet count rose slowly from 24,000 at age one week to 178,000 at seven weeks. The liver and spleen regressed in size but were still enlarged at the time of the last examination. Leukocytosis and the presence of immature granulocytes and normo-

TABLE II.

Isolation of Rubella Virus and Rubella Antibody Titers

		Specimen						
	Time specimen obtained	Urine	Naso-pharynx	Throat	Stool	Bone Marrow	Serum	Serum Antibody Titers
Baby J. T.	6 days	+	+	+	+	N.T.	—	1:64
	52 days	+	+	+	Entero virus	+	—	1:64
Mother	6 days post delivery	N.T.	N.T.	N.T.	N.T.	N.T.	N.T.	1:16
	52 days post delivery	N.T.	—	—	N.T.	N.T.	—	1:32

N.T. = not tested   + rubella virus isolated   — No isolation of rebulla virus

Co-author
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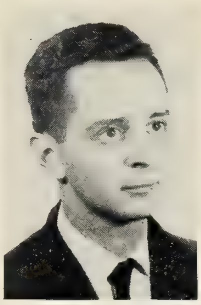

blasts in the peripheral blood suggested a stimulated and active bone marrow.

The real absence of other congenital defects in this infant may be questioned at the present time since it is known that the number of malformation attributable to maternal rubella increases with extended follow up;[10] nevertheless up to two months of age this baby has presented no certain evidence of other congenital anomalies.

The possibility of post-natally acquired rubella seems unlikely because of the early age at which virus was first recovered and particularly in view of its persistence. Furthermore the known association of CTP with maternal rubella and with the other defects of the rubella syndrome strongly suggests that the virus isolated is in fact etiologically responsible. Other cases of CTP caused by rubella have been reported in the literature recently.[3,5,11]

The protracted persistence of virus in the fetal and neonatal period, in spite of good circulating antibody titers in mother and infant, cannot be explained at present, but cases similar to the one reported offer a unique opportunity to study this puzzling host-virus relationship. The large rubella epidemic of 1964 has without doubt resulted in many instances of materno-fetal infection. The fact that the virus persists in certain of these babies should make it possible to increase our knowledge of the malformations associated with maternal rubella. Many centers are now able to carry out this type of virological study either upon referral of the patient or from samples forwarded by mail.

The duration of the virus-carrier state is not known. In another patient (K.A.D.) presenting with a history of maternal rubella in the sixth week of pregnancy, a patent ductus arteriosus and encephalocele were present. Rubella virus was isolated at the ages of 50, 62 and 70 days in spite of a 50 ml blood transfusion received at 56 days on occasion of the surgical repair of his lesions. Two of the nurses caring for this and other infants persistently excreting virus developed clinical rubella confirmed by virus isolation. If these infants had been the responsible contact, clinical disease occurred after the usual incubation periods of two to three weeks.

Recently Cooper at al.[11] have reported that, in connection with the study of an extensive series of offsprings of mothers who had rubella during pregnancy, nine cases of this disease developed among the attendants. The handling of these infants with isolation techniques, the screening of personnel who care for them in the hospital, and the subsequent prevention of contact between these babies and women likely to be pregnant are logical measures to pursue.

SUMMARY

The repeated isolation of rubella virus from an infant with congenital thrombocytopenic purpura is reported. An exanthematous disease compatible with a diagnosis of rubella occurred in the mother during the 8th week of pregnancy. The virus agent isolated, which was identified by its behaviour in tissue culture and through the use of the indirect immunofluorescence technique, is considered to be etiologically related to the occurrence of CTP. Reports of other investigators indicating the persistence of rubella virus from the time of maternal infection until several weeks after birth are briefly discussed.

The epidemiological implications of this protracted virus excretion are summarized. Isolation procedures appear indicated in the care of these babies even though practical measures to avoid exposure of pregnant susceptibles are difficult. Antibody screening of presumed susceptibles in whom rubella is a risk can be performed by neutralization or immunofluorescent assays.

The possibility of diagnostic confirmation by virus recovery offers an opportunity to increase knowledge of the anomalies caused by rubella and of the virus-host relationship in these cases.

Thus, it is desirable that neonates whose mothers had rubella and particularly those who have anomalies be referred to centers where virological studies can be performed. If samples for culture and antibody levels are to be forwarded, proper collection and handling of the specimens are imperative.

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(Continued on Page 928)

SEVERE PSORIASIS COMPLICATING RADIOTHERAPY

Radiation therapy is seldom complicated by severe benign skin diseases. A patient with extensive psoriasis in the therapy portals was successfully treated for a carcinoma of the endometrium using cobalt teletherapy and radium implantation. Dose calculations indicate that the skin dose is similar to that used by some dermatologists for the treatment of psoriasis.

By H. GUNTER SEYDEL, M.D., M.S.

Extensive psoriasis involving major areas of the trunk is seldom encountered as a possible complicating feature of radiation therapy. There are very few references to this problem upon reviewing the medical literature. We therefore consider worthy of reporting a patient encountered on the radiotherapy service who presented with carcinoma of the endometrium, with an associated severe psoriasis involving both the anterior and posterior abdominal and pelvic areas.

In spite of this skin involvement, radiation therapy was administered in the usual manner and tolerated without complication. Skin dose calculations for this patient, and comparison with doses recommended by some authors for irradiation treatment of psoriasis will be given after the case report.

CASE HISTORY

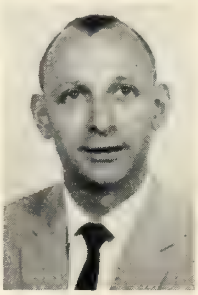
M. K., a 53-year-old white female patient, entered the department with a chief complaint of intermittent vaginal bleeding of three years duration. Two weeks before, she had developed continuous vaginal spotting and was admitted to an outlying hospital. Dilatation and curettage and cervical biopsy were performed, the pathological report showing "adenocarcinoma of the endometrium" and "chronic cervicitis."

When the patient was seen in this department she was in good general condition without active vaginal bleeding and with normal laboratory and x-ray examinations. The last normal menstrual period had occurred approximately seven years ago. Pelvic examination revealed a vagina with normal mucosa. The cervix was small and soft. The uterus was small, anteverted, and sounded to 6 cm. The parametria were free of palpable disease. The skin of the anterior and posterior abdominal wall and of the gluteal and perineal regions was covered with confluent, flaking, lichenified lesions of psoriasis (Fig. 1). Similar lesions were seen on the extremities and on other parts of the skin of the trunk. The patient had been treated by dermatologists with oral and local medications for many years.

Because the uterus was small and could not be packed with Heyman's capsules, it was decided to carry out the routine treatment for carcinoma of the endometrium consisting of cobalt teletherapy followed by radium implant. External cobalt therapy was employed at 50 cm. SSD; the dose to the pelvis was 4880 rads in five weeks; 2860 rads maximum dose were delivered to each of the two anterior and two posterior 12 cm x 15 cm ports which were angulated 40 degrees toward the midline and which were separated by 6 cm. This technique is based upon phantom measurements and produces a uniform dosage throughout the pelvic cavity.

Immediately after the cobalt teletherapy, a medium size Manchester tandem containing 25 mg. of radium was placed in the uterine cavity. It was left in place for 120 hours, delivering 3000 mg hours.

During the radiotherapy and while the patient took daily tar baths and applied a tar-salicylic acid preparation in Aquaphor twice daily, the scaling lesions disappeared and were replaced by tanning



The Author

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From the Radiotherapy Department, Wayne State University, College of Medicine and Detroit Memorial Hospital, Detroit, Michigan.

of the skin in all the areas involved with psoriasis, which extended well beyond the limits of the treatment and exit ports (Fig. 2). The patient also noted significant relief from itching.

Following the patient's discharge from the radiotherapy division there was no change in the appearance of the psoriatic areas until a total hysterectomy was performed in an outlying hospital two months after termination of radiotherapy. The post-operative period was complicated by dehiscence of the wound and the patient experienced an exacerbation of psoriasis with scaling lesions and itching while using 6 mg of triamcinalone and local applications daily. The lesions advanced slightly beyond the previous areas of involvement. Again there was no difference between the areas included in the direct telecobalt beam and the adjacent skin (Fig. 3). The surgical specimen revealed no evidence of malignancy, and there has been no evidence of recurrence of the carcinoma of the endometrium sixteen months after termination of radiotherapy.

DISCUSSION

Radiotherapy has been recommended for the treatment of certain cases of subacute and chronic psoriasis.[1,3-6,10] In recent years, however, oral and external medications, some of which have been mentioned in this case report, have become the most important modalities for treatment of this disease, and radiotherapy has been considered contraindicated except for "that very important once in a lifetime social engagement such as wedding, etc."[2,12] If they advocate the use of ionizing radiation at all, most authors have recommended treatment with grenz rays or soft x-rays up to 90 kv (HVL 0.75 mm Al). The dose varies between single treatments of 150 to 200 roentgens and 75 roentgens weekly for three to eight weeks,[10] 105 roentgens twice weekly for several weeks,[7] and 200 r weekly for up to four weeks.[8] The ultimate total dose per area is given with 1200 roentgens of unfiltered low voltage x-rays[3] and 2000 roentgens for grenz rays.[7] Szur, Silvester and Bewley[11] used the electron beam of an 8 MeV linear accelerator in a patient with widespread psoriasis. They gave 1200 rads in 14 days with good result.

Radiotherapy is effective in a large number of patients but only in the field of treatment. No generalized improvement or improvement in adjacent areas is noted after local x-ray and grenz ray treatment.[8] Also, radiotherapy does not prevent local recurrence of the disease.[8] It has been stated that over-irradiation should be carefully avoided either without giving any reason,[1] or because of a "peculiar resistance of the disease to any form of treatment" in the irradiated area,[10] or on account of the fear of roentgen ray sequelae.[5] No reference could be found in the literature relating to the effect of tele-

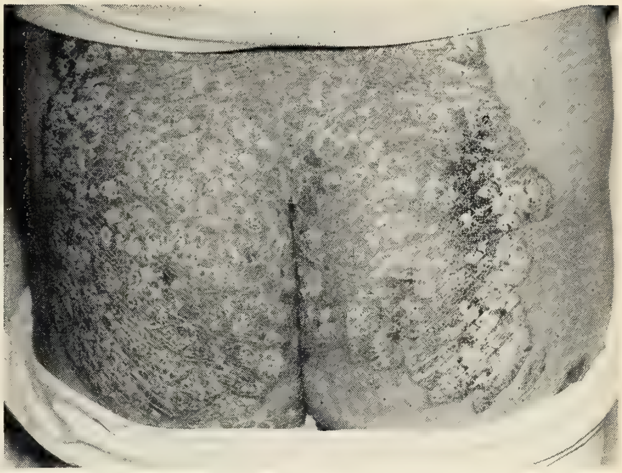
Fig. 1. Psoriatic skin before radiotherapy.

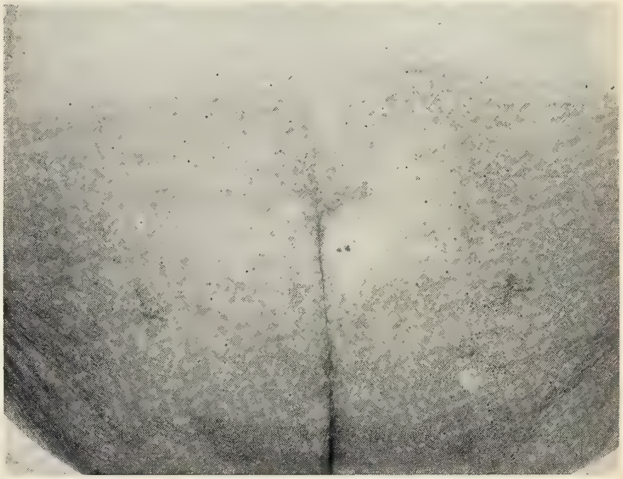
Fig. 2. Psoriatic skin after radiotherapy.

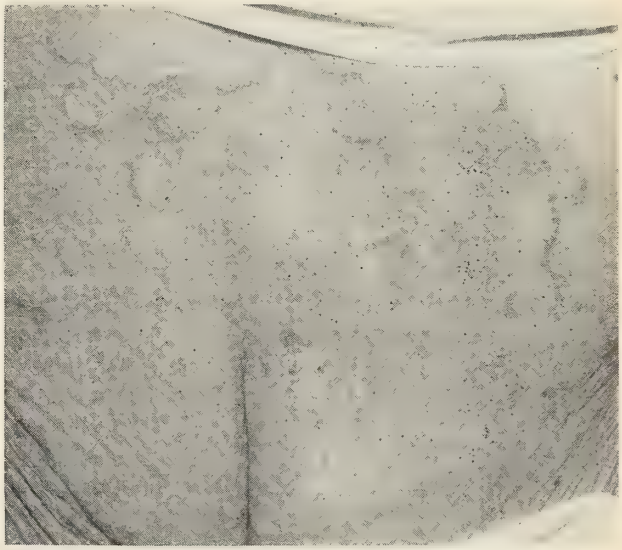
Fig. 3. Psoriatic skin after radiotherapy and surgery.

cobalt irradiation on psoriatic skin.

Therefore, a skin dose calculation was carried out for our patient. Based upon the treatment technique which was described above, the skin dose at the treatment port was 1146 rads, using 40 per cent of the maximum dose as skin dose.[9] The exit port, which overlapped in part the diametrically opposing treatment port, contributed 15 per cent of the maximum dose or 429 rads. The radium contribution was very small with the highest dose being 146 rads to the skin of the abdomen. The total calculated skin dose is 1711 rads for this patient who measured 20 cm in the antero-posterior diameter and 34 cm in the transverse diameter. This skin dose was higher than that quoted by Eller[5] for the treatment of psoriasis, especially when one considers the long protraction usually employed in the treatment of dermatological conditions. However, it is below the total dose employed by Hanfling[7] for grenz rays delivered in a similar period of time. The fact that the skin within the treatment ports and the remaining skin involved with psoriasis showed no difference in reaction during and after radiotherapy indicates that the changes in the skin were not due to the irradiation therapy.

The use of Heyman's capsules only was considered in this patient and had to be abandoned because of the small size of the uterus. Cobalt teletherapy to the pelvis combined with radium implantation was well tolerated, with improvement in the patient's skin condition which is felt to have been due to the dermatologist's medications. As no reports have been published regarding the effect of high doses of low voltage or deep x-ray therapy on psoriatic skin, conclusions can only be drawn regarding the use of super-voltage irradiation. In view of the possible surgical complications due to psoriasis, one of which is demonstrated in this patient, it is important to realize that radiotherapy in adequate dose can be given to such patients if suitable super-voltage equipment is employed. The high skin dose delivered in the irradiation of the pelvis by ortho-voltage radiation makes the use of this type of equipment inadvisable for patients with psoriasis on the skin of the treatment ports.

SUMMARY

A patient with carcinoma of the endometrium complicated by severe psoriasis in the treatment ports is presented. Irradiation treatment consisting of cobalt teletherapy to the pelvis and application of radium to the uterus was carried out, and no adverse effects were experienced in the psoriatic skin. The skin dose for this patient was calculated and it was found to be similar to the maximum doses recommended by some authors for the treatment of psoriasis with low kilovoltage x-radiation.

(The author gratefully acknowledges the assistance of Miss Ann Forsaith in the dose calculations.)

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Congenital Thrombocytopenic Purpura

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Ischemic heart disease usually results from the coincidence of two interacting factors: (1) Impaired coronary O_2 supply (atherosclerosis), and (2) neurogenic (sympathetic) augmentation of myocardial O_2 consumption. The latter is typically elicited by (a) emotional stress, (b) lack of physical exercise (= deficiency of antiadrenergic counterregulation), (c) nicotine. Rational and effective principles of prevention are: Emotional relaxation, regular exercise, non-smoking.

PREVENTION OF "ISCHEMIC" (SO-CALLED "CORONARY") HEART DISEASE

By Wilhelm Raab, M.D.*
Vermont

The fate of the myocardium depends on the relation between its oxygen supply, provided by the coronary arteries on the one hand, and the oxygen consumption by the myocardial tissue on the other. As long as the coronary arteries are normally supplied, they automatically and promptly dilate, bringing in more blood and oxygen whenever the oxygen consumption and demand on the part of the heart muscle rises, and no oxygen deficit will occur.

However, when the coronary arteries become rigid and narrow through atherosclerosis, or if those in the inner layers of the heart muscle are being compressed from inside the left ventricle by high blood pressure, they can no longer adequately compensate for increased amounts of oxygen consumed by the myocardium. A critical "ischemia" will result, leading to electrocardiographic, functional and ultimately structural disturbances (necroses, infarctions).

> Only in about one-half of all infarction cases is a complete occlusion of a coronary vessel by a thrombus or by severe atherosclerotic changes of the vessel wall found at autopsy.

In many instances the coronary arteries are only moderately or even quite insignificantly involved, and the second of the two inseparable factors responsible for the oxygen balance, namely a disproportionately high oxygen consumption, must be accused of having contributed to the clinically manifest event and fatal outcome of myocardial destruction.

It has long been known that the sympathetic nervous system, by means of its neurohormones (the catecholamines, epinephrine discharged from the adrenal medulla into the blood stream, and norepinephrine, locally discharged from the sympathetic nerve endings into the heart muscle itself) dominates the degree of oxygen consumption by the myocardial tissue and greatly augments it under the regulative influence of stimuli coming from the central nervous system (hypothalamus) and from the peripheral sympathetic ganglia.

> Disregard of this elementary principle and one-sided preoccupation with the vascular aspects (atherosclerosis) of myocardial ischemia alone have long and seriously hampered an adequate understanding of the causes of ischemic heart disease and of its preventability by other means than by dietary measures (low fat) which are directed against coronary atherogenesis alone.

Abundant experimental and clinical data from the world literature have made it clear beyond reasonable doubt that the sympathetic nervous system plays an outstanding, fundamentally contributing role in the pathogenesis of ischemic heart disease and that this must be kept in mind whenever rational attempts at practical prevention are planned and organized.

Prosperous, civilized living in industrialized nations, especially in the United States of America, has enormously increased the incidence of ischemic heart disease.

It contributes to both factors which impair a proper oxygen balance in the heart muscle, namely: (a) a reduced oxygen supply due to coronary

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Presented at the Conference on Preventive Cardiology, Battle Creek, March 2, 1965.

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atherosclerosis which is substantially promoted by an excessive intake of dietary fat, and (b) an unduly increased cardiac sympathetic tone and correspondingly increased oxygen consumption due to three main characteristics of overcivilized, sophisticated living.

These are the following:

1. Emotional socio-economic tensions, frustrations and anxieties which stimulate the hypothalamus and thus augment the discharge of norepinephrine and epinephrine (and also of adrenal corticoids which aggravate the cariotoxicity of the catecholamines). They are apt to elicit electrocardiographic signs of myocardial ischemia, and the appearance of necrotic lesions in the heart muscle.

2. Tobacco smoking which stimulates the peripheral sympathetic ganglia, thus causing the discharge of excess catecholamines, results in an increase of myocardial oxygen consumption and in the presence of coronary sclerotic involvement, leads to myocardial ischemia.

3. Lack of physical exercise is demonstrably accompanied by an increase of the cardiac sympathetic tone both at rest and in response to physical, sensory and emotional stresses, as a result of deficient antisympathetic (vagal and sympatho-inhibitory) counterregulation. As long as coronary compensatory dilatability is intact, this does not cause any metabolic detriments to the heart but it becomes dangerous when coronary atherosclerosis supervenes. By contrast, vigorous physical training of a certain minimum degree regularly lowers the cardiac sympathetic tone (reduces the heart rate, prolongs the isometric contraction period) and thus protects the heart muscle from exaggerated oxygen demands which otherwise create a critical discrepancy between vascular oxygen supply and myocardial oxygen consumption in sedentary individuals. Besides, it seems to favor the development for a rich coronary vascular collateral network.

The practical implications of the above-outlined pathogenic principles with regard to the preventability of premature cardiac disease and death are obvious but still widely ignored.

Their most important aspects are: (1) Prevention of coronary atherosclerosis by a low-caloric diet, low in saturated fats, as practiced, e.g., by the "anti-coronary club" in New York City, the Chicago Board of Health, and as prepared by the National Diet Study; (2) Prevention of an unduly high cardiac sympathetic tone, (a) as achieved by systematic physical training programs at the Cleveland Clinics, the Universities of Illinois and Oklahoma, and by community programs in Charleston, North Carolina; Flint, Michigan; Glens Falls, New York, and others; (b) as initiated by the Surgeon-General's campaign against smoking; and (c) as planned by the Preventive Heart Reconditioning Foundation in Vermont which has tried for years to establish in the Green Mountains at least one American Preventive Heart Reconditioning Center comparable to nearly 3,000 such centers in the Soviet Union, East and Central Europe.

> **These centers abroad accommodate about 5 million potential heart disease candidates per year. They are financed by governments, industry and insurance organizations and are located in scenically attractive, usually mountainous, climatically favorable, rural surroundings.**

They combine the principles of systematic intensive physical outdoor training with the powerful psychologically relaxing factor of "getting away from it all" in a pleasant, invigorating environment for periods of at least four weeks, free of charge, on a thorough indoctrination of the life-long adherence to acquired health habits, including diet and non-smoking.

Conclusive statistics concerning the influence of the vast European reconditioning systems on cardiac morbidity and mortality are still missing, but large-scale data are now being accumulated in a five-year study in West Germany. According to the Minister of Health of the Soviet Union, that country has the lowest incidence of ischemic heart disease among all civilized nations.

Investigations of the immediate effect of reconditioning periods in Russian and West German centers on myocardial function have uniformly provided impressive evidence of a beneficial reduction of cardiac sympathetic tone, persisting for approximately one year; also a drastic diminution of absenteeism, and an improvement of work capacity.

Industries in the communist countries and in Japan insert regular exercise breaks into working hours and provide sports and other recreational facilities for workers and personnel. The communist governments conduct perennially extensive campaigns of public education for the life-long maintenance of exercise and general health habits.

Paradoxically, the United States with its unparalleled and uncontrolled premature cardiac mass mortality is still remaining decades behind preventive planning and action in other, far less afflicted countries.

Offer Drug Abuse Manual

A manual, *Drug Abuse*, prepared specifically to help law enforcement officers in their efforts to combat the problem of drug abuse, has been published by Smith Kline & French laboratories. Single copies are available on request from the Law Enforcement Liaison Unit, SK&F Laboratories, 1500 Spring Garden St., Philadelphia, Pa. 19101.

Vote, Help Elect Judicial Commission

This month, each MSMS member will receive a mail ballot in an election to select the new MSMS Judicial Commission. The ballots must be returned to MSMS by December 30.

The Commission, approved by the 1965 House of Delegates, will be composed of 10 members. Wayne County doctors will elect four Commissioners, and the other six districts each will elect one. For this election, the state has been divided into seven districts.

This all began when the 1964 House of Delegates directed that a Judicial Study Commission be appointed by the President to prepare recommendatios for a permanent judicial board and system for MSMS.

The recommendations, which required 10 pages of single-spaced typing, were laid before the 1965 House of Delegates. The delegates, after lengthy debate and the adoption of certain amendments modified the Society's Constitution and several chapters of the Bylaws to a permanent MSMS Judicial Commission.

This action by the House of Delegates constitutes a momentous step, evidencing the progressiveness and vigor of the Michigan State Medical Society in its Centennial year. The Judicial Commission and system adopted by the House of Delegates is considered to be second to none in organized medicine throughout the United States.

Newly-adopted Bylaws spelling ou the procedures for nominating and electing the Judicial Commission call for these matters to be completed by mid-December in 1965 and in early November of succeeding years. Accordingly, the full text of the new Constitution and Bylaws provisions was forwarded to all component county medical society presidents immediately following their adoption. The wording also appears in the House of Delegates Proceedings published this month as part of this issue of MICHIGAN MEDICINE.

Governor Considers Health Recommendations

Governor Romney reports that the recommendations of the Governor's Action Committee on Health Care "are under careful consideration." The Governor congraduated the Committee for its outstanding contributions.

The recommendations urge statewide planning and franchising of Michigan hospitals and health facilities. The report also pointed out that uncoordinated growth can produce "wasteful duplication of facilities, threatening the quality of patient care and representing an economic loss to the community."

The nine-member committee included Myron E. Wegman, M.D., Ann Arbor, chairman; John Rodger, M.D., Bellaire, and Mrs. Marjorie Karker, rural health leader and MSMS staff member.

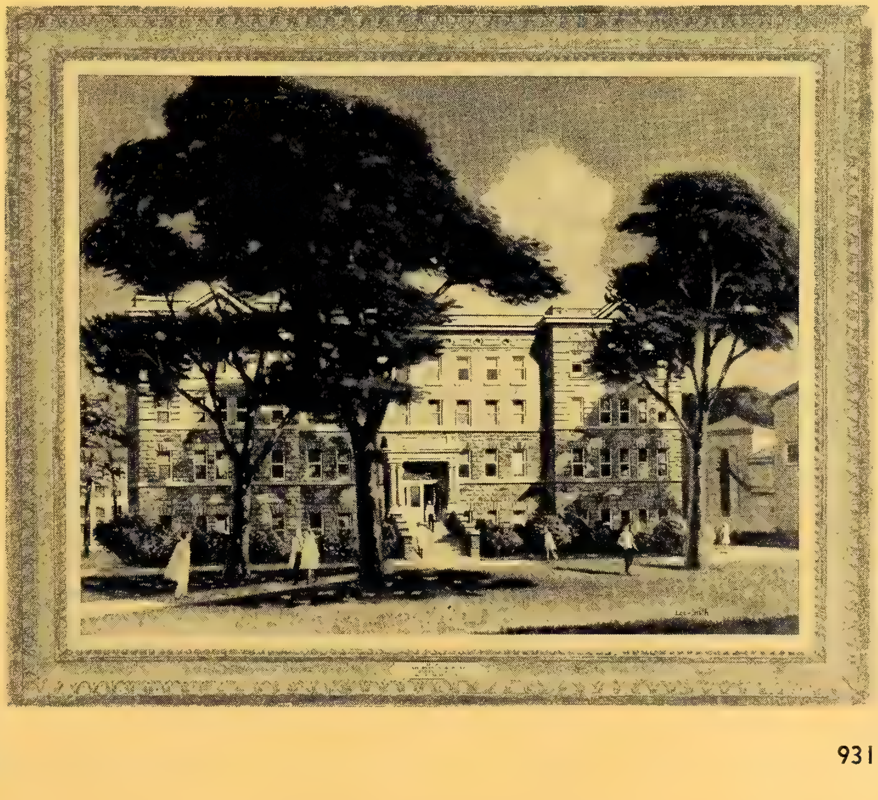
Squibb Presents Painting To University of Michigan

An original oil painting of the University of Michigan Medical School was presented November 12 to its dean, William N. Hubbard, Jr., M.D., by E. R. Squibb & Sons at Ann Arbor.

The painting is part of a long-range plan by the pharmaceutical firm to create a collection of original oil paintings of the medical colleges of America. The project is known as "Collegia Medica Squibb" and will continue until representative paintings of all 86 medical schools have been completed.

The painting shows the West Medical Science Building, a view chosen by Dean Hubbard because it is best remembered by most of the Medical School's 8,000 living alumni. It is the work of Hughie Lee-Smith, an artist represented in a permanent collection at the Michigan Union.

The presentation was made during a luncheon atended by a number of University regents, vice presidents, deans, alumni and student officers, department chairmen and other faculty members. Squibb was represented by George S. Squibb, xice president for public and legal affairs.



"Progress Through Cooperation" was the theme of the MSMS exhibit at the annual convention of the Michigan State Nurses Association in Grand Rapids. The special display explained the work of the MSMS Committee on Nursing, and the exciting Healthmobile.

Proposal Suggests MSMS Set Up "Affiliate" Member Classification

The 1965 House of Delegates has proposed an amendment to the MSMS Constitution which would create a new "affiliate" classification of MSMS membership.

An amendment to the Society's Constitution can only be proposed by the House of Delegates, where it must be discussed in open meeting at an annual session. Constitutional provisions require that the proposed amendment then be either published at least once in the journal of the Society or sent officially to each component county medical society at least two months before the next annual meeting. Only after a full year has elapsed since its having been proposed can the House act to adopt the amendment.

Currently, in addition to active membership, MSMS offers honorary membership, associate membership, life membership, and provides for retired members, non-resident members, and military members. Each classification is described in the MSMS Bylaws.

During the 1965 annual session of the House, the Constitution and Bylaws Committee, in presenting its proposal for "affiliate membership," set forth for information giving the delegates specific details about the new classification and the Bylaws that would be necessary in 1966 if the Constitutional amendment is then adopted.

Presently the Honorary Membership classification is reserved for those who have rendered extremely distinguished and unusual service in either medicine or an allied science, and may be conferred on either a layman or scientist. This classification is held by a very few persons. The Associate Member classification may be held by laymen, interns or residents in training, teaching fellows (for a specified period), physicians in military service and doctors in government posts (also for a limited time), and may also be held by active members who are incapacitated by illness or engaged in postgraduate studies.

The Affiliate Membership as proposed is designed to include allied scientists and their teachers, and physicians working in foreign countries or U. S. possessions who are not eligible to any other class of MSMS membership.

If the Constitutional amendment is adopted in 1966, new ByLaws will provide that "Nominations for affiliate membership may be submitted to The Council by county medical societies or may be initiated by The Council. An affiliate member shall pay no dues and shall not have the right to vote or hold office. He shall have the privilege of attending the scientific assemblies but shall not be entitled to receive any publication of the Society except by subscription.

Reregistration Time Is Now!

Every physician wishing to continue in the practice of medicine shall annually on or before January 1st reregister with the Board of Registration in Medicine on a form to be provided by the Board.

The Reregistration Form, to be signed by the applicant, shall contain his name, his residence address, the address at which he is engaged in practice, and such other identifying information as the Board may require. The annual registration fee is $5.00.

A licensee who fails to register before January 1st shall be so notified by certified mail to his last known address, and until March 1st may reregister as above provided, except that the registration fee for the year shall be $10.00.

A physician duly licensed under the Act shall be exempted from the payment of fees for any calendar year during which he is in the active service of the armed forces of the United States.

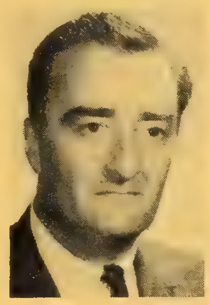
The license of a licensee who has not reregistered before March 1st shall be considered suspended until he has reregistered, at which time he may be reinstated by the Board upon the payment of a reregistration fee of $10.00; no further examination shall be required by the Board as a condition to such reinstatement.

Magazine Reproduces Centennial Symbol

Graphic designers and public relations specialists across the nation have seen copies of the handsome MSMS Centennial symbol. The symbol (and other Centennial art work) was designed by Sequoia Press in Kalamazoo and is reproduced now in a publication, "Dimension," issued monthly by the Simpson Lee Paper Company at Vicksburg for publication executives.

New Executive Of Blue Shield

John C. McCabe, of New York, has assumed his duties as executive director of Michigan Medical Service.



Mr. McCabe was previously senior vice-president of Group Health Insurance, Inc., Group Health Hospital Insurance, Inc., Group Health Dental Insurance, Inc., and vice-president of Group Health Insurance of New Jersey. The companies are medical, hospital and dental insurance plan affiliates with nearly one million subscribers in New York and New Jersey. Mr. McCabe, 42 years old and a life-long resident of New York State, was graduated from Manhattan College and took graduate work at New York University and Columbia University. He is curently a consultant to the Social Security Administration for the Medicare Program.

AUGUSTA—Computers are not utilized quickly enough, James A. Hagans, M.D., the Upjohn Company medical research biostatistics manager, declared here at a special biomedical research conference. Hagans cited delays in the use of computers for clinical drug research.

Dean Hubbard To Lead AAMC

Wm. N. Hubbard, Jr., M.D., Dean of the University of Michigan Medical School, is the new president-elect of the Association of American Medical Colleges. He was elected at the recent annual convention in Philadelphia.

Dean Hubbard will be present during 1966-67 and will succeed Thomas Bourne Turner, M.D., Dean of Johns Hopkins, who is the current leader.

Dr. Hubbard's election climaxed a day in which he successfully led forces seeking to define broadly the association's objectives. A more restrictive view was advanced by several deans, notably from the Southwest.

In balloting, deans from the nation's 94 medical schools put this statement into the asosciation's record:

"The objectives of the association shall be to strengthen, expand, and cooperate with all educational programs that are important to the nation's health, with particular concern for the entire span of education and training for the medical profession and health sciences. The association will foster studies and research, provide means of communication and forums, and perform services necessary to program and policy decisions that the above broad objectives will require."

Lauds Medicine, Stresses Need For Planning

Lieutenant and Acting Governor William G. Milliken proclaimed the week of November 7 through 13, 1965, as Community Health Week in Michigan. His proclamation read:

"Health is the most priceless possession of every man, woman and child; and a high level of health is vital to the safety, growth and progress of our state and citizens.

"Americans today are living longer, healthier lives than ever before because of the enormous advances made in medicine during our lifetime. Medicine and the dedicated people in its many specialized fields have teamed up to conquer polio, smallpox, diphtheria and other dreaded diseases, which once took a heavy toll of life. Medicine's endless search for new miracles to aid it in its goal of having life free from serious disease or crippling injury is reaching toward ever greater heights.

"The citizens of our state are blessed with many excellent health services and facilities which have resulted from organized community efforts and careful planning. We strive to encourage our local communities to have the vision, the essential teamwork and voluntary cooperation, and planning necessary to meet and cope with tomorrow's health needs so that the highest level of health protection and service will be available to all.

"Therefore, I, Lieutenant, and Acting Governor, William G. Milliken, of the State of Michigan, do hereby proclaim the week of November 7 through 13, 1965, as Community Health Week in Michigan, and call upon the citizens, health professions, relevant state agencies, civic organizations and public schools to join in its observance to demonstrate to the people of Michigan the many health services and facilities that enrich their lives, and to encourage community planning to meet their health needs of the future."

Coming in January

Michigan Medicine will welcome 1966 with an excellent original article from the Wayne County General Hospital and the University of Michigan reporting a new treatment agent for production of short-term hypotension in an emergency. George Thompson, M.D., is the senior author.

Case reports on such varied items as acute hemolytic anemia complicating infectious mononucleosis and hydatidiform mole in the older woman are also presented, as is an interesting problem in the identification of human remains. Morris Weiss, M.D., will present important principles in the psychological management of the physically ill adolescent and many will be interested in a report by Maurice E. Castle, M.D., of Mt. Carmel Mercy Hospital, on a simple splint for emergency room use.

Committee Pace Picking Up

Many of the MSMS committees are already at work following their appointment this fall. Some of the work was delegated by the 1965 House of Delegates while other projects are ongoing activities in varied fields of concern.

Following is the list of committees which have been active since the Centennial Session:

September—Maternal Health (MSMS Headquarters).

October—Judicial Nominating Committee, Advisory to Executive Director, Professional Insurance Plans, Alcoholism & Drug Addiction.

November—Medicine & Osteopathy, Advisory to Executive Director, Mental Health, Disaster Medical Care, Cancer, Michigan Cancer Coordinatign, MCCC Program & Budget Committee, Evaluation of Prepaid Medical Services, Liaison with Mich. Crippled Children Commission.

News: And It's Brief

WASHINGTON, D.C.—A total of 1,529 physicians will be drafted during the first part of next year. The military needs in Viet Nam made necessary an increase in the doctors' draft over the 852 called last January and the 1,000 in January, 1964. The 1966 draft will cover physicians who completed their internships from two to five years ago, many of whom now are in private practice.

All those drafted will be given an opportunity to accept officer commissions before induction.

* * *

EAST LANSING—Michigan State has made three key appointments involving its new medical school. The new appointees are:

Theodore M. Brody, Ph.D., as chairman of the Department of Pharmacology. He presently is professor of pharmacology at the University of Michigan; William H. Form, Ph.D., as chairman of the Department of Sociology. He has ben a research professor of sociology at MSU; Francis J. Haddy, Ph.D., M.D., as chairman of the Department of Physiology. He is presently chairman of physiology at the University of Oklahoma Medical Center.

* * *

ANN ARBOR—The Washtenaw County Medical Society Committee on Medicine and Religion is holding four dialogues at St. Joseph Mercy Hospital for doctors and clergy. The first one, Nov. 18, was about "The Care of the Dying;" Jan. 20, "Problems of Pregnancy;" Feb. 17, on "Privileged Communication;" and March 10 on "What Is Life?"

* * *

LANSING—Charles Frantz, M. D., Grand Rapids, and Joseph N. Schaffer, M.D., Detroit, recently were named to the new State Board of Physical Therapists Registrations by Governor Romney.

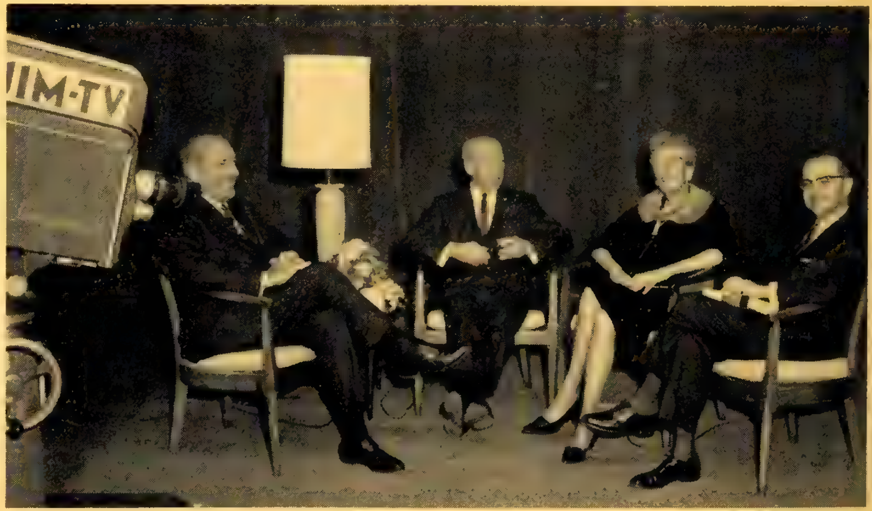
MSMS President At White House Session; Dean Voices Views

The White House Conference on Health, attended by MSMS President Luther R. Leader, M.D., heard some interesting views advanced by U-M Medical School Dean Wm. N. Hubbard, Jr., M.D., Dean Hubbard said, "Health must be viewed as not only survival and prevention of premature death but also the fulfillment of human potential."

"For the human species to persist, the biological thesis of competitive survival must be supplanted by the humanistic idea of the brotherhod of all men," Dean Hubbard declared. He said the "unique socialization and urbanization" of modern man leave "the survival of the human species . . . open to question." He added:

"The entire system necessary for enhancing the health of the people demands manpower at every level. Our current limitations of health cannot be overcome by just improving the distribution of service based on our present state of ignorance."

Donovan F. Ward, M.D., second from left, Immediate Past President of the AMA, came to Michigan to appear on a WJIM-TV show recently to discuss the MSMS Healthmobile and Community Health Week. The "Formula" program, sponsored by the Michigan Association of the Professions, offered views also by Ross V. Taylor, M.D., at right, MSMS Councilor from Jackson; Mrs. Marjorie Karker, rural health leader, and Hugh W. Brenneman, left, MSMS Executive Director, who moderates the weekly program.



OUR STATE SOCIETY

MEDICAL DATA STICKER EFFORT TO BE CONTINUED

(See Cover)

Extensive educational efforts are underway to promote the use of the Medical Data stickers on driver's licenses. The use of posters, news articles, photographs, etc., will continue to urge every physician to regularly make use of the stickers wherever appropriate.

This project was launched by MSMS to coincide with the 1965 observance of Community Health Week during November.

The stickers, designed by MSMS and subsequently approved by the government agency, carry the Society's name, the words "medical data," and sufficient blank space for any comment which the physician deems advisable. The fact that they will become an integral part of the driver's license will, it is hoped, tend to increase the number of persons carrying vital medical emergency data on their persons.

In 1964, the MSMS House of Delegates directed that discussions be held with appropriate state government agencies to determine whether a record of tetanus immunizations could be incorporated in the Michigan driver's license. After these discussions were commenced, a decision was made to completely revise the license itself, and the new license, in addition to carrying a color photograph, is encased in plastic for durability. During its design, the reverse side of the license was left blank to accommodate stickers. The medical data sticker is to be placed on the back of the license, using the bottom edge as a guide.

It was also decided that, while a record of tetanus immunizaton would be invaluable in cases where accident victims suffered open wounds, other vital data might, in the opinion of physicians, be equally pertinent. The sticker therefore may be noted in the physician's discretion with such information as "wears contact lenses," "diabetic," etc.

The Michigan Department of Health is cooperating with MSMS in producing placards for display at driver licensing centers throughout Michigan, to inform those obtaining licenses that they should "ask their doctor" to place any necessary medical information on their license. MSMS is also informing all police and fire agencies of the program, so that officers and firemen will routinely check driver's licenses for emergency medical data.

As further segments of the MSMS program to encourage widespread use of the stickers, the secretaries of all component county medical societies have been requested to invite the program to the attention of members at meetings; a small initial supply of the stickers has been forwarded to each member of MSMS, with instructions as to how additional stickers can be readily obtained without cost; and use of the stickers is suggested to all viewing the MSMS "Healthmobile" as it tours Michigan.

MSMS members may obtain supplies by writing to Stickers, MSMS, Box 152, East Lansing.

MATERNAL WELFARE CONFERENCE SLATED FOR MARCH 24-25

Several outstanding national authorities will be brought into Michigan for the Fifth Annual Michigan Conference on Maternal and Perinatal Welfare at Flint, March 24-25, 1966.

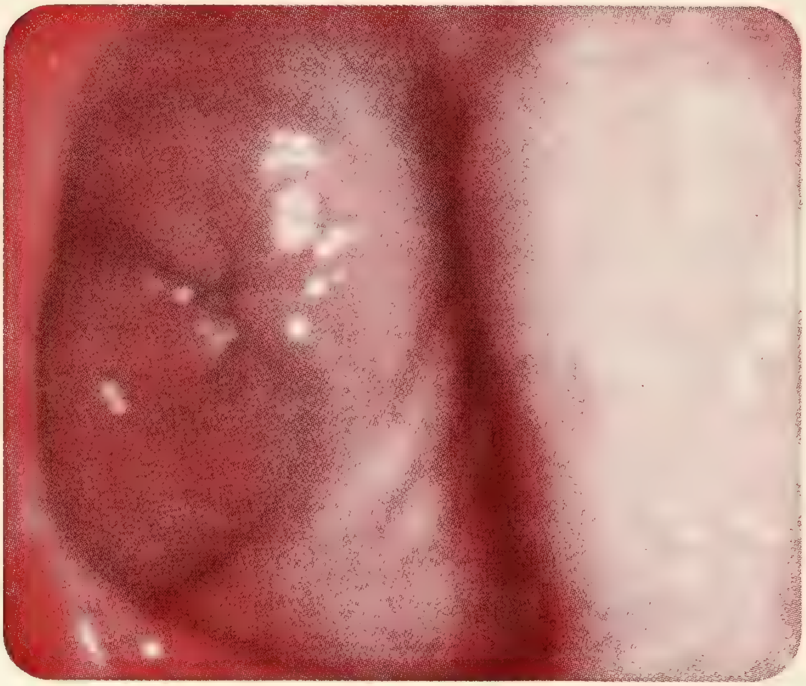
Once again, the conference will be sponsored by the Michigan State Medical Society Maternal Health Committee with the support and cooperation of the Trustees of the Clara Elizabeth Fund of Flint.

The program is virtually complete and will offer recognized Michigan medical educators in addition to several national experts. Early acceptances to come and speak have been obtained from James B. Arey, M.D., Temple University professor of pathology, and Otto C. Phillips, M.D., of Pittsburgh, chairman of the maternal welfare committee of the American Society of Anesthesiologists.

The conference will open at noon on Thursday, March 24, and conclude after the luncheon on Friday, March 25.

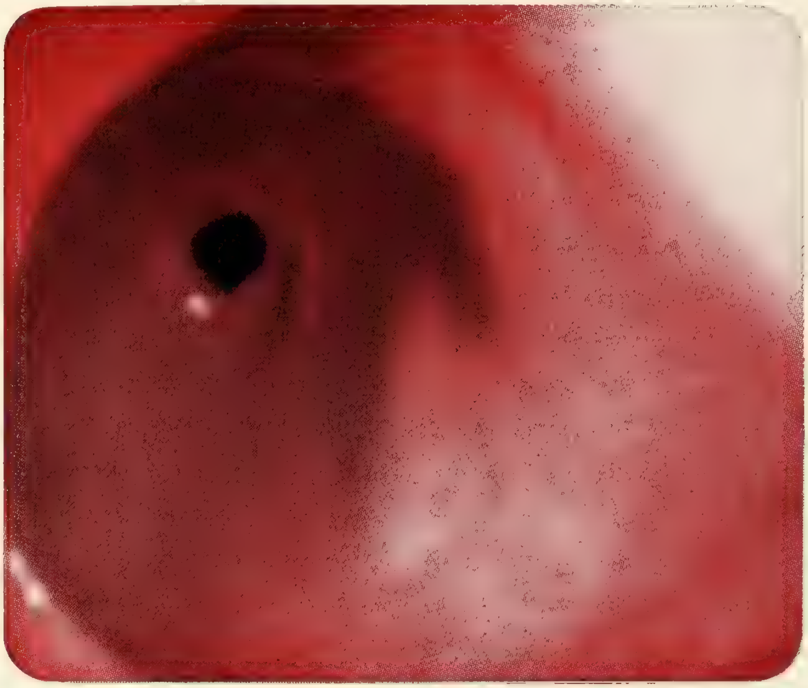
Further details will appear in future issues of MICHIGAN MEDICINE.

Intragastric photography studies[1]



A/ E. B., male, age 48. Normal antral contraction. Pyloric opening is not seen. It is difficult to differentiate a deep prepyloric contraction from a "pyloric fleurette" or true pylorus.

B/ Same subject after 6 mg. of propantheline bromide intravenously; antral contractions ceased. The pyloric orifice remained open and was easily identified. Better visualization of the antrum was also obtained.



Say you saw it in Michigan Medicine

Now you can see Pro-Banthīne® at work

(propantheline bromide)

Pro-Banthīne is so effective in anticholinergic action that it may be employed in visualizing the entire pyloric region.

In addition to the intragastric photographs, cinegastroscopic studies[2] have demonstrated graphically not only its effectiveness but the superiority of Pro-Banthīne over belladonna alkaloids.

Pro-Banthīne produced complete cessation of gastric, antral and pyloric motor activity with a dose of 6 mg. intravenously. This is approximately one-third the usual oral dose of 15 mg.

Atropine at full normal dosages did not produce such cessation. It required double the usual oral dose of atropine, 0.8 mg. intravenously, to duplicate the aperistaltic action of Pro-Banthīne. This dose of atropine produced pronounced discomfort and tachycardia with ventricular rates as high as 150 per minute.

It is this pharmacologic superiority of Pro-Banthīne which has made it the most widely prescribed anticholinergic in such conditions as peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

Dosage—The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15 mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily.

Side Effects and Contraindications—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.
2. Barowsky, H.; Greene, L., and Paulo, D.: Paper read at Meeting of American Society for Gastrointestinal Endoscopy, Montreal, Canada, May 25-27, 1965.

SEARLE

Research in the Service of Medicine

Delegates Stress MMS Payments Must be to MD Who Does Service

Michigan Medical Service rulings regarding the compensation of doctors for services rendered to subscribers were reviewed during the just completed annual session of the House of Delegates.

Two resolutions, one entitled "Payments of Alternate Physicians in Obstetrics and Gynecology" and the other headed "Doctors' Service Reports, Michigan Medical Service," were considered by the House reference committee on Medical Service and Prepayment.

The committee, in recommending that no action be taken on either resolution, cited the Articles of Incorporation of the Michigan Medical Service amended to September 24, 1963 (Article 11) and concurred with the MMS Board that in order to properly conform to the Articles it is necessary for Michigan Medical Service to:

1. *Identify the exact service rendered.*
2. *Identify the doctor who provides the service.*
3. *Identify the patient to whom the service is provided.*
4. *Remit the fee to the physician and notify the patient of this payment or, if the case requires, remit the fee to the subscriber and notify the physician.*

In connection with obstetrical and gynecological cases, the Committee pointed out that in obstetrical delivery the fee provided by Michigan Medical Service is for the delivery itself, and does not include payment for the prepartem or postpartum care.

The two resolutions suggested that MMS make arrangements for payments to the doctor originally responsible for the care of the patient either by assignment of the payment by the doctor who performed the service to the original physician, or by such other method as will meet the requirements of these situations; or that billing procedures permit one physician, in agreement with his colleagues involved in rendering a particular subscriber service, to sign the DSR for himself and his associates, as long as neither he nor his associates rendering the service are interns, residents, or physicians in training.

The Committee suggested that there are occasional situations where the purposes of these resolutions would be convenient or desirable, especially when such arrangements for services to the patient are clearly in his best interests.

Pointing out that flexibility in service provisions to the patient is often desirable, the Committee suggested that flexibility in payment arrangements can be provided by the individuals concerned.

MEDISCENE

Dec. 15-17—"New Frontiers in Health," Michigan Department of Health, Division of Adult Health, Inn America, East Lansing.

Jan. 5-7—Rural and Suburban Sewage Disposal Conference, Kellogg Center, Michigan State University, East Lansing.

Jan. 21-22—14th Annual Symposium on Blood—McGregor Memorial Center, Detroit.

Feb. 6-11—10th Annual Mid-winter Medical Conference, Boyne Mountain Lodge.

Feb. 23—5th Annual Thyroid Workshop, Wayne County Medical Society headquarters, Detroit.

Feb. 25—2nd Annual Nursing Conference, Michigan Heart Association, Sheraton-Cadillac Hotel, Detroit.

March 24-25—5th Annual Michigan Conference on Maternal and Perinatal Welfare, Flint.

April 4—45th Beaumont Lecture by Walter Seegers, M.D., at Wayne County Medical Society Building.

April 6—17th Cancer Day Program, Hurley Hospital, Flint.

April 24—Michigan State Medical Assistants Society 9th Annual Educational Seminar, Empire House Motel, Bay City.

May 2-7—Muskegon County Health Fair.

May 11-13—Michigan Public Health Association, Annual Meeting, Pick-Fort Shelby Hotel, Detroit.

MSMS Statement* On Family Planning Reprinted Again

"The Michigan State Medical Society strongly supports the following concept of Family Planning:

"The current interest in various aspects of family planning and the recognition of the importance of human reproduction, including population control, have put emphasis on the responsibility and need for leadership from the medical profession.

"The very personal nature of this advice and counseling in family planning makes it mandatory that consideration be given to the patient's wishes and desires, her ethnic and religious background. The physician or clinic must be prepared to counsel on all the various aspects of family planning, whether in assisting a couple to have a family, or, at the other extreme, in assisting a couple to postpone additions to their family. In the latter regard, expert counseling in the technique of rhythm should be just as readily available as expert advice in the newer forms of family planning."

---

*Adopted by MSMS Council.

On Stelazine® brand of trifluoperazine
she's calm and alert

When a tranquilizer is needed, 'Stelazine' can regulate the level of anxiety so that the patient is unlikely to overreact to stress but is not tranquilized into psychic inertia. Patients on 'Stelazine' often experience a sense of mental alertness and, because they feel so much better, are more interested in their normal activities.

Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects,* usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems.

Before prescribing, see SK&F product Prescribing Information.

Photograph professionally posed.

SK&F

Smith Kline & French Laboratories

EDITORIAL VIEWS

Another Centennial

This year The Salvation Army observes the one-hundredth anniversary of its founding.

Almost from the beginning, The Salvation Army has been a partner of the medical profession. In 69 countries and geographical areas, the Army supports and administers a great network of hospitals and related institutions geared to the requirements of the locale. Services and institutions as diverse as a leprosarium in India and a full-time podiatrist at a shelter for the homeless in London are offered to the needy of every race, color and creed. And, of course, modern general hospitals are an important part of The Salvation Army's ministry here and abroad.

THE "D.W." ASKS:

WASAMA is the Woman's Auxiliary to the Student American Medical Association. It is encouraging to note the interest and activity of this organization of medical student wives. The Ann Arbor WASAMA group recently held a panel discussion on the topic of "The Doctor's Wife." These wives of doctors-to-be submitted questions for the panel which your editor found to be most encouraging as a sample of the perspicacity, curiosity, and effective thinking being done by these young women. Officers of our auxilary served as panel members and Mrs. Clarence Crook deserves the credit for the organization thereof.

Here are the questions for the panel, as the student wives submitted them. You will note that the nickname for themselves is "D.W." as an abbreviation for the Doctor's Wife.

A. *Professional Involvement:*

1. How can the D.W. keep herself informed on current medical trends from the profesion's point of view as compared with information in the public news media?
   Which medical or professional publications should she have on her reading list?
2. What are important medical ethics which the D.W. should understand?
   Is it ethical for the D.W. to give advice to a patient?
3. Should the wife let her husband tell her about personal health problems of his patients?
4. How much should a wife influence her husband as to the field of medical work he does or where they live?
5. Should the D.W. help in her husband's office?
6. What are some general techniques for answering the telephone?
7. What are benefits of being a member of a medical auxiliary?

B. *Community Involvement:*

1. Should D.W. be involved in community organizations?
   What about political involvement?
2. In how many and in what kind of organizations should a D.W. participate?
   Are pressures put on D.W.'s to do organizational work?
3. Are pressures brought on the doctor if his wife refuses to be involved in community activities?
4. Are wives of interns and residents expected to participate in community affairs?
5. Does having small children exempt the D.W. from contributing her time to community organizations?

C. *Questions on Family Life*

1. What qualifications does a doctor's wife require in greater than usual degree?
2. How does a wife cope with the disappoint-

ments to herself and/or the children when family plans are disrupted?

3. What are some of the problems of raising doctor's families with "part-time" fathers?
4. What are some responsibilities the wife must assume regarding family finances?
5. From the D.W.'s standpoint, how would responsibilities differ in a partnership practice as compared with private practice?
6. Some practical advice for keeping friends while coping with broken social engagements, late dinners, etc?

D. *General*

1. Should a D.W. who has not completed her education (i.e., degree) before her marriage, attempt to do so after she is married?
2. Does the D.W. generally accompany her husband to conventions?
3. How does a D.W. respond to such comments as "All Doctors are rich?"
4. Can a D.W. be a career woman and fulfill her responsibilities to her home and family?
5. Should a doctor's family have a family doctor?
6. What can doctors' families do to show appreciation for professional courtesies?
7. What is unusual about being an army doctor's wife?

C. J. Tupper, M.D.

Never Before . . .

Never before has the individual physician been more needed in his medical organization; never has he needed it more than he does today.

It is essential that we have greater participation by more physicians at all organizational levels, supported by competent, dedicated staff.

The physician must strive to be a complete, effective citizen, concerned not only with the art and science of medicine but also knowledgeable in its socio-economic environment.

—F. J. L. Blasingame, M.D.
AMA Executive Vice President
At 1965 AMA PR Institute

Doctor, *DO YOU KNOW...*

that the Michigan State Medical Society sponsors the following Group Insurance Plans for its members:

Life Insurance
2 plans available including coverage for dependents

Special Accident
Death & Dismemberment up to $100,000

Long Term Disability

Professional Overhead Expense

Write for Descriptive Brochures without obligation

Ben P. Stratton, Administrator
P.O. Box 547
Lansing, Michigan 48903

A Century of Service

A great many residents of this state will have an opportunity during the coming year to become acquainted with a comprehensive story of "A Century of Service in Michigan Medicine."

The phrase quoted above will be the slogan used in connection with the forthcoming tour of a Healthmobile which was dedicated to the service of the public during the Michigan State Medical Society Centennial Convention in Detroit in September.

By means of authoritative exhibits housed in the mobile unit, a 12x50-foot trailer, the State Medical Society and the Michigan Health Council plan to tell the people of more than 50 Michigan communities of some of the exciting developments in medical research and health care. Another important purpose is to interest young people in careers in the health field.

The Healthmobile's story will cover a period beginning in 1822 when Dr. William Beaumont, stationed with American troops at Mackinac Island, conducted the famous experiments that provided the medical profession with its first reliable information on the physiology of digestion. The story will extend through the Civil War period, on through the turn of the century and to date. A projection into the future will deal with implications of the advent of space age medicine.

Those who visit the Healthmobile during its display beginning Friday at Frandor Shopping Center and during subsequent displays in Michigan will have access to a dramatic portrayal of progress in medicine and the continuing contributions by members of the medical profession.

We congratulate the State Medical Society and the Michigan Health Council upon their performance of another public service by making the story available.

(Note: The above editorial from the **Lansing State Jornal** appears on the side of the Healthmobile, for the visitors to read as they enter the Healthmobile door.)

A.H.C.P.
PLEASE TAKE ONE!

AMERICAN HEALTH CREDIT PLAN

A Service For You And Your Patients

And this service begins by informing your patients about the American Health Credit Card, which permits them to pay you immediately for the health and medical services you perform.

That's the job of these American Health Credit Plan brochures contained in this attractive office and waiting room dispenser. You should have one by now, but if you don't and would like to receive the full story on how A.H.C.P. benefits you, send a note to:

American Health Credit Plan of Michigan, Inc.
11 Green Street, Battle Creek, Mich.

A.H.C.P. and the U.S. Mail will do the rest.

Nitroglycerin
Belladonna
Paregoric
Codeine
Cortisone
Aspirin
Digitalis
Vitamins
Penicillin
Miltown®

An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

Miltown®

(meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its antianxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

WALLACE LABORATORIES
Cranbury, N.J.

CM-5761

Hudson Discusses Federal Medicine

"To remain free, the medical profession must prove to the American people and to Congress—by positive, progressive, imaginative actions—that we and our allies can demonstrate that the quality and availability of care are better and will be maintained better under development of our present system than might be expected under a governmental system."

So declared AMA President-Elect Charles L. Hudson, M.D., in his speech at the University of Michigan Medical Center Alumni Conference.

Doctor Hudson, a native of Merrill and a graduate of Alma College and the University of Michigan, declared:

* * *

"MY BELIEF IS that government control would without a doubt adversely affect the relationship of physician and patient, would impair the privilege of this special communication, would restrict and direct the physician in his practice needlessly, would impose clerical burdens on him, would affect the personal satisfactions of the physicians and thus would adversely influence the supply of physicians."

While stating these strong personal beliefs, Doctor Hudson warned that doctors must stop being complacent and start leading the way themselves in changing the forms of medical practice. He noted that the forces for change included government, voluntary organizations, medical progress, medical costs and patient demands.

* * *

DOCTOR HUDSON mentioned specifically three forms of a community health services—the consumer groups, the idea of comprehensive health programs and emergency room services—as "exerting their impact on medical practice."

"Physicians still have an opportunity to exert leadership in the development of desirable community health programs, but we must become active immediately."

He suggested that often community health programs, which are formed, for example, to meet the medical needs of the mentally ill or indigent, occasionally go beyond their original descriptive bounds of size and form "and develop into something more ominously comprehensive."

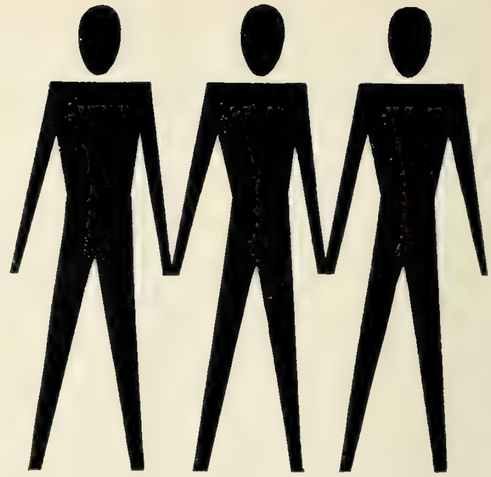
* * *

IN CLOSING, Doctor Hudson declared:

"As I see it, American medicine can be a pivotal group in preserving significant values that are inherent in this nation's way of life and in the provision of medical service.

"While the practice of medicine in the future will be vastly different from today or 25 years ago, there will be a sameness to it. And that sameness will be that the physicians, individually and together, will use their talents to improve the health of the people—their patients.

"The future of medical practice is developing and changing now. Only your intelligence and leadership, your good will, and your guidance and advice will direct the changes toward better care of the sick and greater fulfillment of the hopes and aspirations of physicians."



SOCIO-ECONOMIC

Hospitals Serve More Patients

There were a record 26.0 million admissions to hospitals last year, up 720,000 from 1963. The average length of patient stay was 7.7 days in 1964.

The average cost per hospital stay in 1964 was $320.17, up from $299.61 in 1963. The American Hospital Association said the boost was due, in large measure, to the increase in hospital personnel and the related rise in personnel expense.

Not only have wages of hospital personnel gone up faster than average, in order to bring them in line with the rest of the economy, but the modern non-federal short term general hospital has more personnel per patient—2.42 in 1964 as compared to 1.98 in 1953.

Health insurance benefits last year paid $5.1 billion worth of hospital bills, compared to $4.6 billion in 1963, and $2.6 billion in doctor bills, up from $2.3 billion.

The average cost to the hospital per patient day in non-federal, short term general hospitals in 1964 was $41.58, nearly double the $21.76 of ten years ago.

pain
anxiety
tension
for the comprehensive control of the pain cycle

TRANCO-GESIC®

CHLORMEZANONE with ASPIRIN

100 mg. 300 mg.

NON-NARCOTIC ANALGESIC,
with tranquilizing and muscle relaxant properties

In low back pain

sciatica, lumbago; musculoskeletal pain associated with strains and sprains

In tension headache

premenstrual tension and dysmenorrhea

Because pain is frequently aggravated and perpetuated by both anxiety and muscular tension, the combination of aspirin with a well tolerated tranquilizer—muscle relaxant (Trancopal® (brand of chlormezanone)) is exceptionally effective.

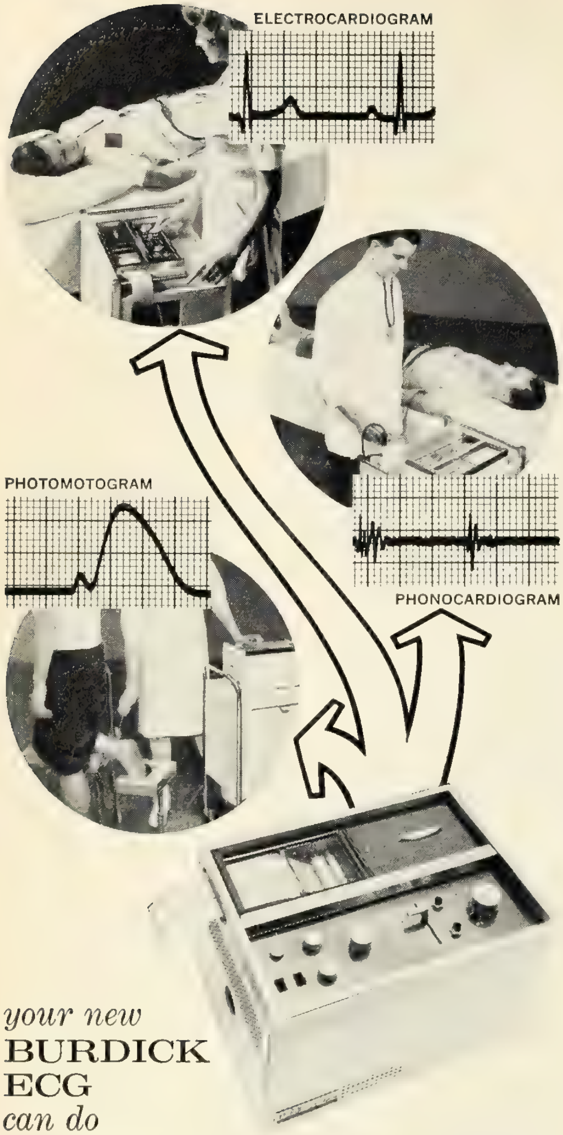
TRANCOPAL is a "Tranquilaxant" which calms anxiety and tension, relieves muscle spasm, and enhances the analgesic effect of aspirin by subduing *emotional responses* to pain.

Side effects such as gastric distress, occasional weakness, sedation or dizziness may be noted. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. TRANCO-GESIC should not be administered to persons known or suspected to have an idiosyncrasy to acetylsalicylic acid.
Dosage for adults is usually 2 tablets three or four times daily, the suggested dosage for children from 5 to 12 years is 1 tablet three or four times daily.
Supplied in bottles of 100 and 1000 tablets.

1967M

Winthrop

Winthrop Laboratories
New York, N. Y. 10016



your new
BURDICK
ECG
can do
TRIPLE DUTY

The new Burdick electrocardiograph gives you a precision recorder of high fidelity. And, while it is designed primarily to record electrocardiograms, the same unit with auxiliary equipment can be used to record **phonocardiograms** (heart sound) and **photomotograms** (Achilles tendon reflex).

So let your electrocardiograph do triple duty! When you purchase your new Burdick ECG, include the **PC-100 Heart Sound Preamp** and **FM-1 Photomotograph.** Have the benefits of your own office diagnostic grouping for better patient service. Call your nearest Burdick dealer today, or write The Burdick Corporation, Milton, Wisconsin 53563.

THE G. A. INGRAM COMPANY
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Telephone: TEmple 2-4444

Options Reviewed for Insurance Settlement

By Ben P. Stratton
MSMS Insurance Consultant

Although you are probably aware that the principal sum of your life insurance policies may be paid to your beneficiary in a variety of ways, it seems appropriate to review the options of settlement that are available.

It is obvious that the sudden receipt of a large sum of money by a widow who is probably in a state of shock could have disastrous results.

Settlement options enable you to foresee the needs of your family and make the decisions now that are in their best interest. Your life insurance agent, your trust officer, and your attorney are all available to help you select the proper arrangement.

* * *

LET US REVIEW the options that form a part of practically all life insurance policies on today's market.

1. Cash Settlement: This is used where immediate cash is required. This option is automatic in most cases when a formal agreement is not in effect.
2. Payment of Interest: The principal sum may be left with the insurance company and interest will be paid to the beneficiary. The beneficiary may be empowered to withdraw all or part of the principal or to elect another option.
3. Payment of Income for a Certain Period: Interest and principal are combined and paid at specified intervals in accordance with the agreement in effect. The purpose of this option is to provide income needed for a specific period of time such as during the dependency years of children.
4. Payment of Income of a Certain Amount: Here again interest and principal are combined but an amount of income is specified by the agreement and this will continue until the available proceeds are exhausted.
5. Payment of Income for Life: The purpose of this option is to guarantee an income that the beneficiary cannot outlive. This option illustrates one of the most unique advantages of an insurance policy. This is the combining of interest and principal and paying an income for an indefinite period even though the recipient lives far longer than the mortality tables suggest. Usually a minimum period is established such as 10 or 20 years. If the beneficiary does not live at least as long as this minimum period, the remaining balance is paid to a contingency beneficiary.

* * *

A COMBINATION of the above options is usually indicated when you decide on the type of settlement agreement that fits your own requirements. Let us consider a typical situation.

The wife is 38 years of age and there are four children aged 12, 10, 6, and 3. It is determined that the following needs exist:

1. Cash clean-up fund of $40,000. This will liquidate the $25,000 mortgage on the family residence, pay all current indebtedness and final costs.
2. Monthly income of $1,000. This will continue during the dependency years of the children.
3. Emergency fund of $10,000. This can be drawn on for sudden and unexpected expenses. In the meantime it is earning interest.
4. College fund for children. An additional $2,000 annually will be available as each child reaches college age and will continue until graduation.
5. Life income for widow. When there are no longer dependent children, the widow will receive a reduced income of $400 which will continue as long as she lives.

Perhaps now would be a good time for you to review your own policies to determine if changes are indicated in your options of settlement or whether these should be added to your program.

* * *

REMEMBER YOUR LIFE insurance agent and your attorney are available to help you make the most effective use of this valuable service offered by the insuring companies.

Tells Facts About New Drug Stores

A financial investment of $41,860 was required for each of the 2,295 pharmacies that first opened their doors in the nation in 1964, it was revealed in the second annual new stores survey appearing in "Drug Topics" recent issue.

Opening merchandise inventory averaged out to $24,690 per store, an increase of 13.4 per cent over the $21,775 recorded in 1963. Fixture investments came to another $12,363. Additional building and improvement costs at owner's expense of $4,807 brought total investment to $41,860.

The "Drug Topics" study shows about a third of the new stores were in city neighborhood and business centers, another third in suburban shopping centers, and the rest in small towns and other suburban areas.

Offer Insurance Booklet

The Health Insurance Institute offers the seventh annual edition of its booklet, "A List of Current Health Insurance Books."

The 48-page booklet lists a total of 190 books, 31 periodicals, and 34 organizations dealing with the financing of health care.

A single copy is available from Health Insurance Institute, 277 Park Avenue, New York, N. Y. 10017.

PRESSEL ENTERPRISES PRESENTS

STREAMLINE TRAVEL HOMES

your home away from home

Ever thought of living on wheels and take the luxury of your home with you? Then look at the new modern STREAMLINE TRAVEL HOME. It has the same facilities. The interior is custom designed, giving you your choice of a floor plan, materials, and colors. A luxurious living room and dining area, with convertible sofas. The kitchen has a four burner range with oven, refrigerator with freezer, and double sink. A complete bathroom with combination tub and shower, lavatory and toilet facilities. All aluminum aircraft construction, V-8 Industrial engine, power steering, power brakes, and automatic transmission. One ton air conditioner and forced hot air heat. A 5,000 watt generator providing 110 volt power system, and also a 12 volt system. Radio and TV. Comfortable sleeping accommodations for six persons. Pinpoint your map to any destination and your TRAVEL HOME will be completely self-contained with all of the pleasures this 20th century can offer.

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Federal Survey Finds 9 of 10 Aging Paid Own Medical Costs

The Social Security Administration's 1963 Survey of the Aged, covering the year 1962, found:

- *The median income of aged couples was $2, 875.*
- *Nearly one-third of the aged couples had incomes below $2, 000.*
- *Nonmarried persons — widowed, divorced, separated, and never married—make up half of the population aged 65 and over; their median income was $1,130.*

Median total assets of aged couples were valued at over $11,000. Ten per cent of all aged couples had no assets. Equity in a home represented the largest single asset; if home ownership is disregarded, the median for remaining assets is $3,000 for couples, and about $700 for nonmarried persons.

About nine out of 10 aged couples paid their own medical costs without governmental or voluntary agency help; these costs averaged $442—the median was $239. Eight out of 10 nonmarried persons paid their own medical care costs, averaging $270.

One in four couples, and one in seven of the nonmarried who paid their own medical costs received hospital care in 1962, and the total costs averaged $1,200 for couples and $1,000 for nonmarried persons

AHCP-AHA Offer New Service

The American Health Credit Plan has completed purchase of the American Health Agency, Inc. Both firms are located in Battle Creek.

According to Chairman of the Board, W. Earle Robinson, C.L.U., the American Health Agency will introduce a new catastrophe-hospitalization insurance program designed specifically for members of the American Health Credit Plan. "Now by combining American Health Agency coverages with AHCP, members can have a total medical, health, and catastrophe program which can meet virtually any illness, treatment or accident situation."

For additional information, write: The American Health Agency, 11 Green Street, Battle Creek.

NUMBER OF PHYSICIAN VISITS

PER PERSON PER YEAR, BY SEX AND AGE
IN THE UNITED STATES, JULY 1963-JUNE 1964

AGE	BOTH SEXES	MALE	FEMALE
All ages	4.5	4.0	5.1
Under 5	5.5	5.7	5.3
5-24	3.4	3.0	5.6
25-64	4.8	3.9	5.6
65 and over	6.7	6.0	7.1

Source: United States National Health Survey, United States Department of Health Education and Welfare.

DRUG WHOLESALE PRICE INDEX

DOWN SIXTH YEAR

The Wholesale Price Index for Ethical Pharmaceuticals has declined for the sixth straight year.

The index fell during 1964 from a level of 86.2 to an all-time low of 86.0 (1949 equals 100.0).

Austin Smith, M.D., President of the Pharmaceutical Manufacturers Association (PMA), said, "The significance of this index to the public is that wholesale drug price trends are exceedingly favorable when viewed against the price records for all commodities in recent years. While all wholesale prices have risen more than 20 per cent, wholesale drug prices have declined 14 per cent."

ADD 7,911 DOCTORS

A total of 7,911 physicians were newly added to the licensed medical profession in the U.S. in 1964, according to the report by the AMA Council on Medical Education. There were 6,605 newly licensed U.S. and Canadian medical school graduates and 1,306 graduates of medical faculties in other countries.

A total of 17,885 licenses to practice medicine and surgery were issued during 1964 by 55 authorized boards in the U.S. and its territories. This total included first licenses for new physicians, licenses for physicians moving to other states, and licenses for foreign-trained physicians.

As of December 31, 1964, there were 284,271 physicians in the U.S. (excluding 1,740 temporarily in other countries).

Expenditures for Health, Education, Welfare Rise

It is estimated that total public and private health, education, and welfare expenditures for fiscal year 1964 amounted to $108 billion. This figure compares with $35 billion in 1950.

The $108 billion* for 1964 breaks down as follows:

Health	**$35.4 billion (26% public, 74% private)**
Education	**$31.0 billion (80% public, 20% private)**
Social Insurance and Welfare	**$41.1 billion (85% public, 15% private)**

*Total private expenditure amounts adjusted to eliminate duplication resulting from use of cash insurance benefits to purchase medical care and educational services.

STRESSCAPS
following infection

STRESSCAPS B and C vitamins in therapeutic amounts... help the body mobilize defenses during convalescence...aid response to primary therapy. The patient with a severe infection, and many others undergoing physiologic stress, may benefit from STRESSCAPS.

STRESSCAPS®

FOR PROFESSIONAL RECOMMENDATION ONLY

Stress Formula Vitamins Lederle

Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 (one month's supply) and 100 (three months' supply).

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY Pearl River, N.Y.

8693-4

COUNTY SOCIETIES

Varied Activities Serve the Public

The Marquette County Medical Society cooperated with the Ishpeming PTA to show a film, "A Quarter Million Teen-agers," to provide information about teen-age venereal disease.

* * *

The Monroe County Medical Society assisted the Monroe County Historical Museum to set up a special medical display during the MSMS Centennial. Old-time instruments were featured.

* * *

The Marquette County Historical Society highlighted an attractive display of photographs and instruments during the MSMS Centennial. An excellent feature article appeared in the Marquette Mining Journal, telling about early accomplishments of **Marquette County Medical Society** members.

* * *

The Washtenaw County Medical Society cooperated with the University of Michigan Medical school, the Ann Arbor News and the Ann Arbor Jaycees to offer several medical forums at the Rackham Lecture Hall.

* * *

The Kent County Medical Society was lauded recently in a Grand Rapids Press editorial for honoring 18 policemen from the department's ambulance crews at a dinner. The editorial, in part, declared ". . . it is especially gratifying to see the community's physicians publicly acknowledging the importance of this contribution, since no one is in a better position than they are to appraise it."

* * *

The Branch County Board of Supervisors has under consideration a formal request from the **Branch County Medical Society** for an ordinance requiring motorbike riders to wear protective equipment. The society contends that protective headgear, reflective clothing and protective footgear could reduce serious injuries.

* * *

Muskegon County Medical Society held a tetanus immunization day on Tuesday, November 9, with 60 doctors participating. Several thousand inoculations were given. The "Medical Data" stickers were given to the people to place on their driver's licenses.

* * *

Two speakers from the University of Texas will travel to Flint for the annual **Genesee County Medical Society** Cancer Day, April 6, Among the speakers selected for the program are Texans Felix N. Rutledge, M.D., on "Management of Patients with Advanced Cancer of Ovary and Endometrium," and R. Lee Clark, M.D., on "Cancer Therapy: Present Status and Future Trends."

The all-day program at the Merliss Brown Auditorium of the Hurley Hospital will begin at 9:30 a.m. and continue to 5 p.m.

Further details will appear in future issues of MICHIGAN MEDICINE. Interested doctors may obtain information from Max E. Dodds, M.D., Chairman, Cancer Day, Genesee County Medical Society, 806 W. Sixth St., Flint.

* * *

Walter Seegers, M.D., Detroit, has been selected to present the 45th annual Beaumont Lecture, April 4, at the **Wayne County Medical Society** building. The selection was made by the WCMS Lectureship-Historical Committee.

* * *

The **Oakland County Medical Society** has created a community trust with the excess cash that Oakland residents contributed in 1964 to the oral polio immunization program. Governor Romney, represented the citizens of Oakland County, accepted a check for $200,000 recently at a community dinner.

Governor Romney, in accepting the trust check, declared, "Without question we can hold down the cost of government with the aid of such voluntary efforts." The fund will be used to provide financial support for worthwhile programs in education, culture, science, religion, and other community-oriented activities.

* * *

Twelve Western Michigan college students in various fields of training for medical-health careers have been awarded full-year tuition grants by the Kent Medical Foundation. The awards were announced by the **Kent County Medical Society**, administrators of the foundation.

Two of the young men are pre-medical students, and the other youths are in such fields as nursing, pre-dental, laboratory programs and social work.

LIFT

2½-3 times more potent than papaverine with a longer duration of action

NON-NARCOTIC

SPACOLIN™

(Alverine citrate)

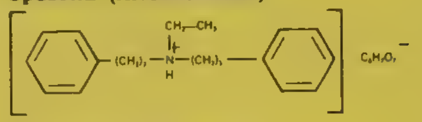
is a potent smooth muscle antispasmodic particularly effective in relieving spastic colon* and spasm of the biliary tract.

*"The diagnosis is based upon a history of catharsis or enema habit, dietary indiscretion or emotional strain, generalized or lower abdominal distress of the type described, abnormality of the bowel movement and tenderness along the course of the colon." *Cecil and Loeb, A Textbook of Medicine, Tenth Edition*

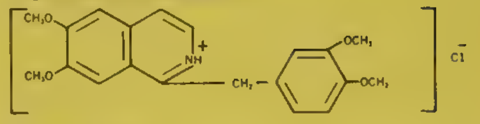
SPACOLIN™ *(Alverine citrate)*

- A specific musculotropic counter-spasmodic.
- NOT an anticholinergic, therefore, has no atropine-like side effects.
- In man, its spasmolytic effect is two and one/half to three times stronger than papaverine with a longer duration of action.
- Neurotropic effect only 1/150 that of atropine.
- Has little or no effect on normal muscle tonicity and motility.
- Specific effect on the *sphincter of Oddi.*
- Mild local anesthetic effect and decreases gastric acidity.

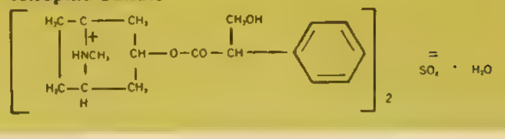
The chemical structures of Spacolin, Papaverine and Atropine are as follows:



Spacolin (Alverine citrate)



Papaverine Hydrochloride



Atropine Sulfate

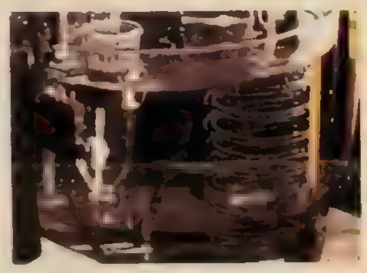
the interesting results *in vitro* and *in vivo* with

NON-NARCOTIC **SPACOLIN™** **120 mg. tablets**

(Alverine citrate)

the potent musculotropic counter-spasmodic 2½-3 times stronger than papaverine

IN LABORATORY



Studies with isolated tissue have furnished investigators with important information as to the qualitative and the quantitative activity of certain therapeutic agents. This technique consists of recording the motility of a segment of rabbit ileum suspended in Tyrodes solution at a constant temperature of 37.5°C. The movements of this smooth muscle strip are recorded on a kymograph. The rabbit ileal muscle is remarkably sensitive to spasm-producing drugs. Once a spasm has been initiated, additions of a very small quantity of a musculotropic agent produces an immediate relief of the spasm or relaxation of the muscle. The study of SPACOLIN along these lines indicated the following:

1. SPACOLIN has little or no effect on normal smooth muscle tonicity. The addition of Spacolin to a normal ileum muscle strip does not change the muscle tonus or contraction.

2. SPACOLIN is a musculotropic counter-spasmodic having an activity more than twice that of papaverine.

3. SPACOLIN is a weak neurotropic spasmolytic agent with an activity of approximately 1/150 that of atropine sulfate.

IN MAN

Double-Blind Study of a Spasmolytic Compound[1]

By ITALO EVANGELISTA, M.D.

Assistant in Medicine, Tufts University School of Medicine, Boston, Massachusetts; Medical Staff, Cambridge City Hospital, Cambridge, Massachusetts; Malden Hospital, Malden, Massachusetts; Whidden Memorial Hospital, Everett, Massachusetts.

RESULTS*	ACTIVE MEDICATION		PLACEBO	
Excellent	9	80%	1	25%
Good	11		5	
Fair	3	20%	7	75%
Poor	2		12	
TOTAL	25		25	

***Excellent** complete relief of symptoms during therapy
Good — definite relief but still aware of symptoms periodically
Fair — symptoms reduced in intensity but still present
Poor — little or no therapeutic benefit.

". . . a definite conclusion could be drawn from the study, namely, alverine citrate (Spacolin), is an excellent aid in the management of spastic gastrointestinal disorders."

---

[1] To be published

SPASM IS HELL

THE GATE OF HELL. -- RODIN

SPACOLIN™* IS HELPFUL

(Alverine citrate)

*A SPECIFIC MUSCULOTROPIC COUNTER-SPASMODIC

100 Tablets
SPACOLIN™
(Alverine citrate)
120 mg.
KEEP BOTTLE TIGHTLY CLOSED
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc.
COLUMBUS OHIO, U.S.A.

NON-NARCOTIC

For fast relief of spasm

PRODUCT INFORMATION

Each tablet contains: Alverine citrate (Bis-gamma-phenylpropylethylamine citrate) . . . . 120 mg.

INDICATIONS: Smooth muscle spasmolytic for use in **spastic colon,** spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer†, cardiospasm, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations.

†Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, cardiospasm or pylorospasm, administer tablets ½ hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort.

PRECAUTION: Caution is recommended when using in hypotensive patients.

SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

SUPPLIED: Bottles of 100 and 500 — 120 mg. tablets.

PHILIPS ROXANE LABORATORIES
Division of Philips Roxane Inc., Columbus, Ohio
"First with the Retro Steroids"

ANCILLARY SECTION

Evans, Fox to Head WSU Departments

Two new department chairmen have been appointed at the Wayne State Universty School of Medicine by Ernest D. Gardner, M.D., dean. Tommy N. Evans, M.D., was named professor and chairman of obstetrics and gynecology and Clement A. Fox, M.D., professor and chairman of anatomy.

Dr. Evans, formerly professor of obstetrics and gynecology at the University of Michigan, succeeds Harold C. Mack, M.D., department chairman since 1962. Dr. Mack is retiring from administrative responsibilities but will continue with full-time academic duties as professor of obstetrics and gynecology. Dr. Evans, who received his M.D. degree from Vanderbilt University, is a former president of the Michigan Society of Obstetricians and Gynecologists.

Dr. Fox, formerly associate chairman of the anatomy department at Marquette University, received his Ph.D. degree from the University of Michigan. He fills a vacancy created by the death of Dr. Ferinando Morin in November, 1964.

BOYNE MEETING SET

The Tenth Annual Mid-Winter Medical Conference will be held at Boyne Mountain Lodge, Boyne Mountain, February 6-11.

For information, contact Richard L. Thirlby, M.D., 228 South Madison Street, Traverse City.

RE-ELECT DR. ADLER PRESIDENT OF MMS

Sidney Adler, M.D., Detroit, has been re-elected President of Michigan Medical Service by the Board of Directors. Dr. Adler, first elected to the Blue Shield Board in 1960, has served as president since 1961.

Other officers named by Blue Shield include:

Ferry B. Allen, of Michigan Bell Telephone Company, Detroit, re-elected first vice president; James B. Blodgett, M.D., Detroit, elected second vice president; Walter J. Zimmerman, M.D., Royal Oak, elected secretary; and Harry S. Rudy, of the Detroit Bank and Trust Company, re-elected treasurer.

U-M Medical Center Begins Fund Drive

Ten thousand alumni of the University of Michigan Medical Center are being asked to start yearly contributions to help the center "do better what it is already doing well." The first annual fund drive of the Medical Center Alumni Fund was launched at the Center's Alumni Conference in October.

Chairmen from each class since 1915, from every state in the union, and from each specialty society, will organize regional campaign teams to approach alumni personally.

The drive aims at "better training for future doctors and nurses, better care for patients in our hospitals, greater efforts to find cures the world needs, and better service for you and your successors."

The annual campaign was decided on last spring as a means to support projects which are not covered by money from the university, state and Federal governments, foundation grants or tuition.

The fund's national chairman is E. Gifford Upjohn, M.D., of Kalamazoo.

WSU Plans Symposium On Blood, Jan. 21-22

The 14th Annual Wayne State University Symposium on Blood will be held in the McGregor Memorial Conference Center, January 21 and 22.

The presentation of papers, to begin at 8:45 a.m. Friday, will deal with "Physiology of Hemostasis and Thrombosis." The Friday evening dinner will be held in the Crystal Room of the Park Shelton Hotel, preceded by a social hour. The suggested accommodation for guests is the Park Shelton Hotel, located near the conference center.

On Saturday, the scientific session on blood will be from 8:45 a.m. until noon. Chairman Walter H. Seegers, M.D., cordially invites everyone interested to attend.

Rename Millard to National Medical Assistant Committee

Glenn E. Millard, M.D., Detroit, was elected to another three-year term on the advisory committee of the American Association of Medical Assistants at its annual convention in New York. Doctor Millard also was presented an award from the AAMA in recognition of his contributions to the organization.

Miss Betty Lou Willey, of Port Huron, a past president of MSMAS, was elected vice-speaker of the House of Delegates for the American Association of Medical Assistants. She was chairman of the Reference Committee on Constitution and By-Laws during the convention.

Twenty-six members of the Michigan association participated in the convention. The MSMAS Bulletin, edited by Mrs. Mary Jordan, received a third-place award.

The St. Clair County Bulletin, edited by Mrs. Carolyn Gemoules, received a second-place award in its division.

Establish New Clinic At Mary Free Bed

The Mary Free Bed Guild Children's Hospital in Grand Rapids has received a grant of $10,000 from the National Foundation to support the initiation of a clinic for pediatric nervous system and muscle diseases. The grant recipient and director of the clinic is Fred A. Baughman, Jr., M.D., neurologist.

Case referrals should be directed to Mrs. Marion Blackford at Mary Free Bed Hospital, phone GL 8-1517, extension 49.

Clinics are scheduled for the first and third Thursday of each month.

By definition, the broad group of mental deficiencies are included in the scope of this clinic. Infants and children with apparent neuromuscular dysfunction deserve a thorough neurological evaluation. This applies, as well, to those with gross somatic malformations, for the rate of coexistence of malformation or significant dysfunction of the central nervous system is from 80 to 90 per cent.

Active teaching and clinical research programs will be integral parts of the clinic. Resident physicians and interns from regional hospitals will be invited to participate. Advanced diagnostic, genetic and biochemical techniques, such as chromosome analysis and amino acid chromotography, will be available.

Patients referred by private physicians will ordinarily be charged a nominal sum, yet to be determined. Patients under A.D.C. or the Michigan Crippled Children Commission will be seen for the fee allowed by the referring agency. In general, payments received will be used for the support of the clinic and its programs.

Description: Hygroton, brand of chlorthalidone, is an oral diuretic agent of value in the treatment of edema and hypertension. The drug is notable for its prolonged action (48-72 hours) and low toxicity. It is not a thiazide and may often be employed successfully in patients who are intolerant of other agents or become refractory to them.
Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000. For full details, see the complete prescribing information.

Hygroton®
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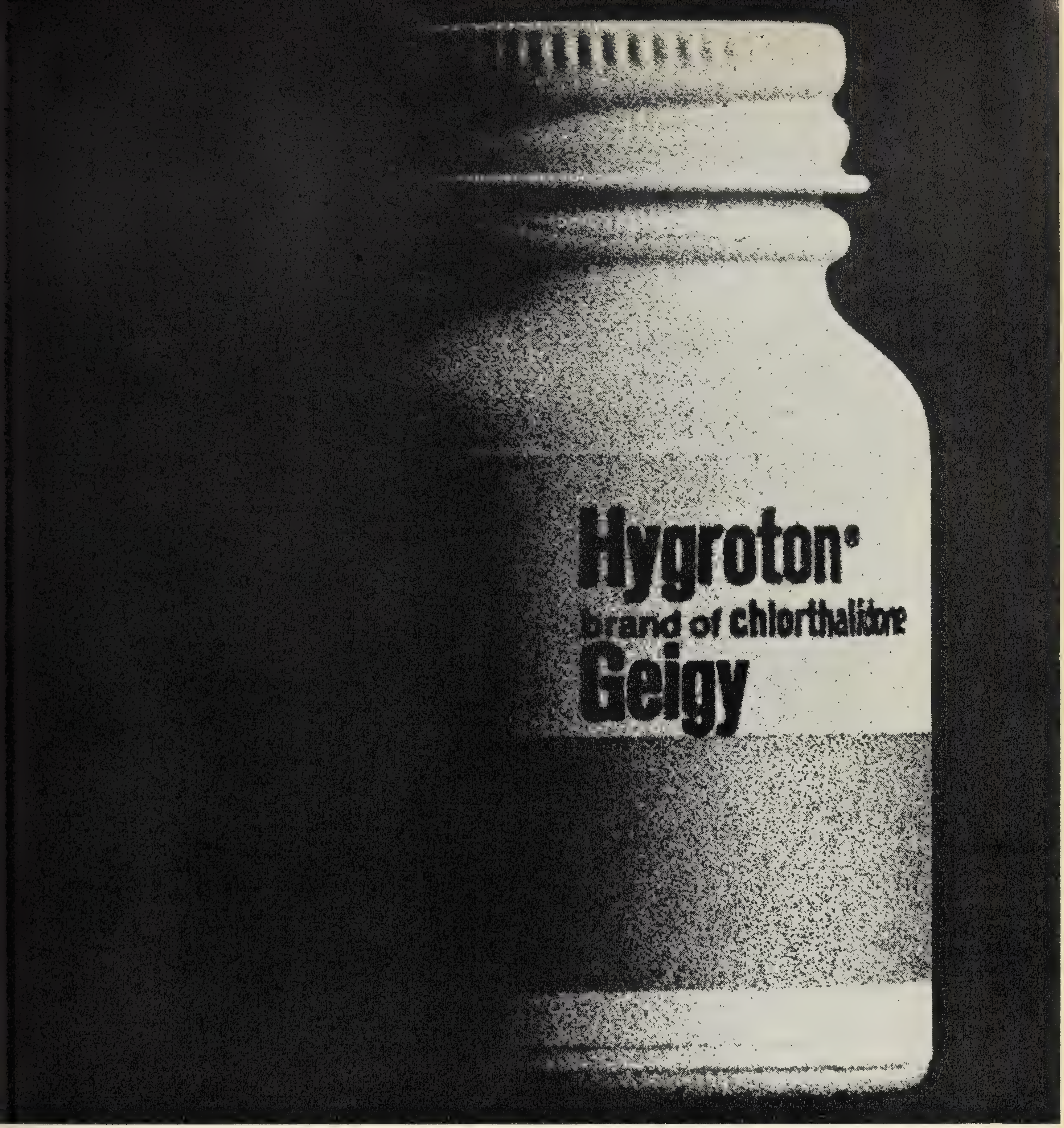

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PRESCHOOL HEARING, VISION SCREENING RESULTS REVEALED

By MICHIGAN DEPARTMENT OF HEALTH

For many years, the screening of school children for vision and hearing defects has been an accepted part of Michigan's school health services program.

In fact, Michigan was the first state in the nation to establish such programs on a state-wide basis. This came about because it was clear that any impairment of sight or hearing could have a serious effect upon a child's emotional, intellectual, and vocational development.

As experience was gained in such school screening programs, however, it became equally clear that for many children, school screening programs came too late. By age five or six, successful correction of such conditions as amblyopia ex anopsia, for example, may be impossible, whereas blindness in the "lazy eye" may be prevented by identification and treatment during the preschool years. Thus a logical extension of school-age screening programs was the development of programs aimed at the preschool child, to detect problems as early as possible when there was the best chance of correcting them.

* * *

IT IS ESTIMATED that about 50,000, or 5 per cent, of Michigan's nearly one million preschool children will enter school with seriously defective vision; that the same number suffer from potentially handicapping hearing losses; that from 7 to 10 per cent suffer from disorders of speech or retardation in language; and that one out of every 25 boys and one of every 250 girls have defective color vision.

Perhaps more significant, hearing and vision defects with the exception of color-blindness are found more frequently among the poor and the mentally retarded. One study indicates that children from low socio-economic areas have more than twice as many vision defects as do children from high socio-economic areas. Another study shows that more than half of the mentally retarded children suffer from communicative disorders which interfere with the achievement of which they might otherwise be capable. Indeed, these communicative disorders are often found in the so-called culturally deprived children in combination with other handicapping conditions.

Thus preschool vision and hearing screening programs have gained increased importance. Last year, for example, hearing technicians employed by local health departments and trained by the Michigan Department of Health tested more than 12,000 preschool children in 13 counties. Of these, 664 were referred to locally conducted otological clinics for examination.

During that same time, about 20,000 preschool children were tested in 26 vision screening programs by vision technicians similarly employed and trained and of these 947 were referred to eye specialists for follow-up.

* * *

CURRENTLY, GREATER attention is being directed toward children in the high risk groups; the culturally and economically deprived and the mentally retarded. It is believed that by correcting vision and hearing defects, both of these groups of children will be able to improve their educational achievement. In some cases adequate correction of vision and hearing defects will keep the child out of special education.

Of particular interest in terms of vision screening is an ambitious program now taking place in Detroit. This is a city-wide preschool vision screening program which is being co-sponsored by the Michigan Department of Health, the Detroit Department of Health, the National and the Detroit Societies for the Prevention of Blindness, and the Wayne County Medical Society.

Vision consultants from the state health department and Detroit ophthalmologists have worked together in training the technicians to do the screening. This program is one of the first in the nation to attempt to reach all preschoolers between the ages of three and five in a major metropolitan area with a vision screening test.

Ultimately it is hoped that it may be possible to develop both vision and hearing screening programs which reach all children in Michigan at least once between the ages of three and five.

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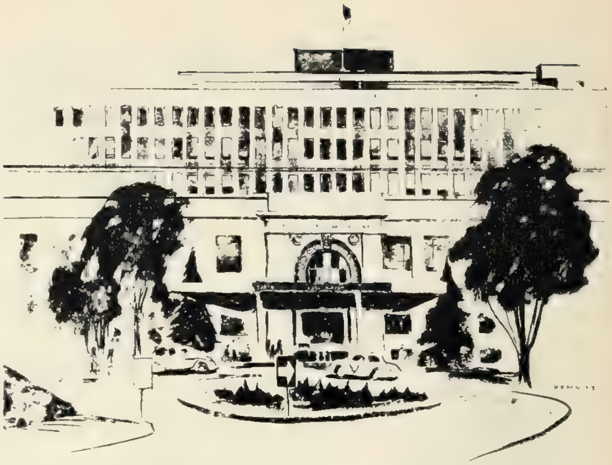

AS SEEN BY ARTIST

The above sketch of the University Hospital is reprinted from "Michigan Memories" a new book about the University of Michigan, edited by Robert Forman, with drawings by Milton Kemnitz, and verses by Richard Emmons. It was published by Hellenic Publications, 2411 Buckingham Road, Ann Arbor.

Mercywood, Accredited Psychiatric Hospital

Mercywood Hospital, a private psychiatric hospital, operated by the Sisters of Mercy in Ann Arbor, has received notification of a three-year accreditation by the Joint Commission on Accreditation of Hospitals. Mercywood, established in 1924, becomes the *first and only private psychiatric hospital in Michigan* to be accredited by the Commission.

Mercywood is a member of the American Hospital Association, The Michigan Hospital Association, The National Association of Private Psychiatric Hospitals, The Central Neuropsychiatric Hospital Association and The Catholic Hospital Association.

Mercywood is licensed by the Michigan Department of Mental Health and has been approved by the Michigan Board of Nursing for basic psychiatric nursing.

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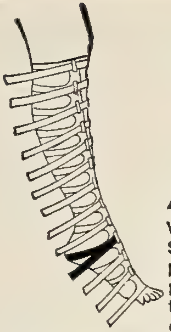

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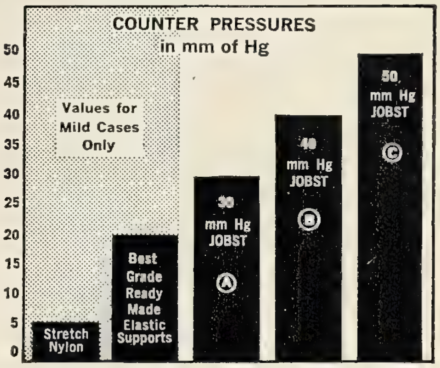

A To assist Fluid Dynamics; Venous Stasis; Post Phlebitis Syndrome.

B Varicose Veins; Chronic Venous Insufficiency; Lymphedema 1 + Pitting.

C Lymphedema 2 + Pitting and higher.

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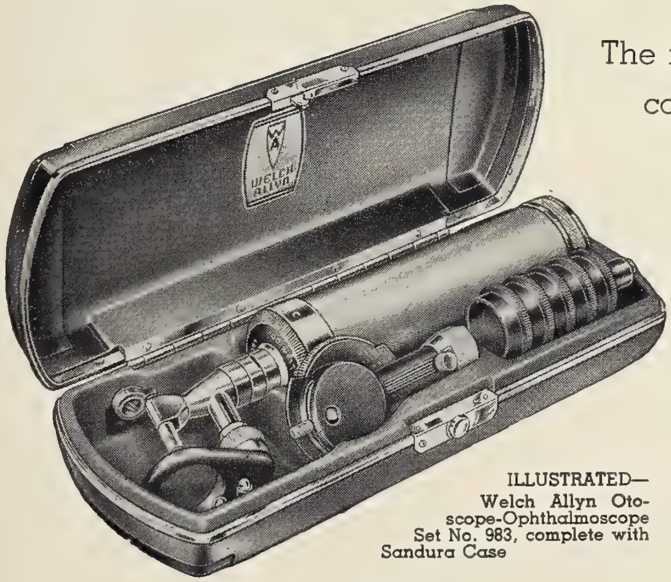

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Tells AMA Story

A new film outlining activities of the American Medical Association in helping to create the best possible environment in which physicians can practice effectively is available from the AMA's Film Library.

Titled "The Critical Dimension," the film is aimed primarily at physician audiences. The environment in which a doctor practices is "the critical dimension" from which the film takes its title. The 16 mm sound film is in color and its running time is approximately 25 minutes.

The film may be obtained from the AMA Film Library, 535 N. Dearborn, Chicago, 60610.

Recalls Work of Early Houghton Area Doctors

The curator of the Houghton County Historical Museum has submitted some biographic material to MSMS about early physicians in that area.

Among the material sent by Mrs. Ruth G. Butler were the following excerpts from "History of the Upper Peninsula of Michigan," published in 1883: "Isaac M. Rhodes, M.D., born in New York in 1830, is physician and surgeon to the Franklin and Peninsular Mines. . . . He was graduated from the University of Michigan Medical School in 1853. . . . Doctor Rhodes has achieved quite a reputation as an inventor, having a passion for mechanical inventions; he has devoted his spare hours from the practice of his profession to his favorite occupation. One of the most important results of his efforts in that direction is an improved surgical chair and splint, for which he received the first premium at the Centennial Exposition of the United States at Philadelphia in 1876. This chair and splint has received the highest commendation of the medical celebrities of this country."

The old history also contained information about Charles Hafenreffer, M.D., Houghton; E. H. Pomeroy, M.D., Houghton; A. Overfield, M.D., Hancock and Houghton; John P. Mason, M.D., Portage Lake; Alfred David, M.D., Adams Township; Henry Isler, M.D., Calumet; R. H. Osborn, M.D., Calumet; W. H. Solis, M.D., Allouez; Christopher J. Woolway, M.D., Eagle Harbor.

Michigan M.D. Authors

Feden Mavromatis, M.D., Lansing, "Tetracycline Nephropathy," Journal American Medical Association, Vol. 193, No. 3, July 19, 1965.

J. W. Conn, M.D.; E. L. Cohen, M.D.; D. R. Rovner, M.D., and **R. M. Nesbit, M.D.**, Ann Arbor, "Normokalemic Primary Aldosteronism," Journal American Medical Association, Vol. 193, No. 3, July 19, 1965.

DINGMAN LEADS NATIONAL FOUNDATION PROGRAM

Reed O. Dingman, M.D., chief of plastic surgery at the University of Michigan Medical School, is the new president of the Foundation of the American Society of Plastic and Reconstructive Surgeons.

The Foundation is a society branch which sponsors original research and an international teaching program. Foundation scholarship winners visit medical centers in the United States and abroad to observe, lecture, operate and conduct clinics.

In 1963-64, Dr. Dingman was president of the society itself.

BOOK REVIEW

The Hormone Quest, Albert Q. Maisel, Random House, New York, 1965, 262 pp., $5.00

What a pleasant contemplation! How exciting to realize an orderly presentation of recent medical history, painted by an artist.

Mr. Maisel notes in an orderly fashion the trials, successes, and failures inherent in discovery, clinical experimentation, large scale manufacture, medical acceptance, distribution, and expense involving new drugs. He doesn't hesitate at pharmacologic, economic, and demographic barriers.

Although many hormones are mentioned, most pages are devoted to "the pill." The bibliography of experimenters is satisfactorily complete, possibly too much so for easy reading. Most interesting to Michigan readers is a reference on page 205 to a pioneering article in *Michigan Medical News*, advocating the teaching of contraception, illegal in

The most obvious weaknesses involve quotations out of context and the obvious problem of condensing so much history into such a compact story. Is this book too scientific for the layman or too "novelish" for the physician? I believe the author has struck a happy mid course.—RALPH V. AUGUST, M.D.

BOOKS RECEIVED

Rypins' Medical Licensure Examinations (10th Ed.). Edited by Arthur W. Wright, M.D., Professor of Pathology, Albany Medical College of Union University; Senior Pathologist, Albany Medical Center Hospital; formerly Secretary, New York State Board of Medical Examiners. 840 pages + xiii. Published by J. B. Lippincott Company, East Washington Square, Philadelphia, Pa.; price $12.50.

Today's Health Guide—A Manual of Health Information and Guidance for the American Family. 640 pages—colorfully illustrated. Published by American Medical Association, 535 N. Dearborn, Chicago, Illinois; price $4.95.

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WATERFRONT OPPORTUNITY: An architectural masterpiece that is located on beautiful Elk Lake. Built and designed for a doctor who has kept the property in practically new condition. Features are too numerous to mention in this ad, but complete details will be mailed to interested parties. Priced at $45,000. Many other waterfront listings available in nearly all price ranges. Member, Partridge & Associates, Inc., Zimmerman-McDonnell Realty Company, 874 East Eighth Street, Traverse City, Michigan, Phone WI 7-7390.

WANTED: Psychiatrist and General physician for full-time staff positions in private psychiatric hospital currently in process of increasing range of inpatient and outpatient services. Midwest Metropolitan Area. Private practice opportunities after one year. Salary open according to qualifications. Attractive working conditions. Fringe benefits. Write Box No. 15, 120 W. Saginaw Street, East Lansing, Michigan.

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MEDICAL SUPERINTENDENTS, Top Administrative Positions in a Challenging Program. The Michigan Department of Mental Health is now considering candidates to fill vacancies as Medical Superintendent. Positions are available in facilities for the retarded and the mentally ill.

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These openings present a unique opportunity to participate in one of the most dynamic mental health programs in the country. Our state hospitals are participating in the community mental health center program as well as training and research activities.

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MEDICAL TECHNOLOGIST: ASCP certified or eligible. Modern clinical laboratory. Excellent salary and benefits in a 360-bed general hospital with large expansion and building program for 1965. Apply: Edward W. Sparrow Hospital, Personnel Office, Lansing, Michigan.

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WANTED — PHYSICIAN, preferably general practitioner, to work full time at the Emergency room of Annapolis Hospital, Wayne, Michigan. Salary depends on number of hours spent on duty—$10.00 per hour. Applicant must have Michigan license. For further information contact: G. Petropoulos, M.D. Responsible Physician of Annapolis E.R. Department.

SITUATION WANTED: Medical assistant to aid in laboratory and office procedures in the Downriver area of Detroit. Please call DU 1-7597, ask for Lynne Gerhardt.

ANESTHESIOLOGY — 2-year career residency now available; $10,000/yr. salary; Ann Arbor Veteran's Administration Hospital. Integral part of University of Michigan Anesthesiology Department. Write to Dr. R. B. Sweet, Dept. of Anesthesiology, University Medical Center, Ann Arbor, Michigan.

WANTED: Two physicians seek one or two general practitioners for established group in Northern Michigan. Medicine, obstetrics and major surgery. Open-staff hospital adjacent. Rotating call schedule. Near Michigan Technological University. Salary to start, partnership possible after six months. Laurium Medical Group, 146 Osceola Street, Laurium, Michigan.

LOCUM TENENS position wanted. General Practice and minor surgery for now and 1966. 42 years old, 10 years in active private and clinical practice. Michigan license. Reply Box 16, 120 West Saginaw Street, East Lansing, Michigan.

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LEGISLATIVE AFFAIRS

Review Work of 89th Congress

By the American Medical Association

To many veteran Washington observers, the First Session of the recent 89th Congress was by far the most active in passing Presidential programs than any other Congress in recent history. By the time the 89th Congress had adjourned, 16,882 bills had been introduced of which almost 950 affected medicine, medical care or the public health.

By comparison, during the First Session of the 88th Congress, approximately 14,000 bills were introduced and in the entire two-year term of the 88th Congress there were only 860 bills of special interest to medicine.

During the First Session of the 89th Congress, the AMA offered its views to the Congress on 17 different subjects. Among the bills which were suported, either in full or in substantial part, were H.R. 2, the Drug Abuse Control Amendments, (P.L. 89-74); H.R. 2984, the Health Research Facilities Amendments, (P.L. 89-115); H.R. 2986, the Community Health Services Extension Amendments, (P.L. 89-109); H.R. 7484 to provide for the rank of Lieutenant General or Vice Admiral of officers of the Army, Navy or Air Force for serving as Surgeons General, (P.L. 89-288); S. 597, the Medical Library Assistance Act, (P.L. 89-291); S. 306, the Clean Air Act Amendments, (P.L. 89-272); H.R. 3727, the Eldercare Act, some concepts and provisions of which were incorporated into H.R. 6675, the Social Security Amendments of 1965; and various amendments to the Internal Revenue Code which would liberalize the Keogh Act provisions for retirement plans for self-employed individuals and which would clarify the tax status of certain professional associations and corporations formed under state law.

The AMA also supported provisions of H.R. 3141, the Health Professions Educational Assistance Act, which extended the program of construction of medical schools, but opposed, among other sections, the provision for federal support of operating expenses for medical schools. H.R. 3141 became Public Law 89-290 on October 22, 1965.

The AMA opposed H.R. 2985, which would provide federal payment of the cost of staffing in mental health centers (the construction of which centers the AMA supported in the 88th Congress); H.R. 2987, loans and mortgage insurance for group practice facilities; S. 596, regional research and treatment centers for heart disease, cancer and stroke; and a number of restrictive laboratory animal care bills. The AMA also opposed the medicare provisions of H.R. 6675, and the provisions which brought self-employed physicians under the compulsory provisions of the Social Security Act, but supported, with certain suggested amendments, other provisions relating to medical care programs for those in need of medical assistance.

In addition, the Association submitted three informational statements pertaining to physician dispensing of eyeglasses, Federal medical care for merchant seamen, and health care for retired personnel of the Armed Forces and their dependents.

The Second Session of the 89th Congress will convene on Monday, January 10, 1966, at 12 noon. At that time, it may be expected that the Congress will turn its attention to health bills still pending such as the Keogh Amendments, the Hart bill (Medical Restraint of Trade Act), and several medicare amendments.

Other health care legislation will be recommended by the President in his annual health message to the Congress.

Legislative Committee Studies DO Proposal

The House State Affairs Committee is continuing its study of medical education in Michigan, and reportedly will give further consideration in January to the bill to establish a state-supported College of Osteopathic Medicine at Pontiac. This past session the bill passed the Senate but was held in the State Affairs Committee.

The Committee is conferring with medical school officials and a subcommittee has viewed several osteopathic colleges.

Reporting As Ordered

A MONTHLY COMMENTARY

By Hugh W. Brenneman

EXECUTIVE DIRECTOR

The variety of mail crossing this desk is *endless*. But one of the best categories is the compilation of compliments regarding the Centennial Session. This is manna to the spiritual stomachs of the official family and the staff, and the file is fat.

The Centennial Session is now a part of the past it celebrated. The thoughts the Session engendered need not be passe, however. Quite the contrary. Professional pride has been the motivating force for that extra effort that doctors have always put forward.

Following up on the annual meeting takes almost as much time as preparing for it. This was especially true this year because of the added emphasis of the Centennial feature. Have you ever tried writing over 500 individual thank you letters with over 250 of them containing checks? Of course, you don't have to worry nearly as much about what you say if a check is included with the Thank You.

1965 LEGISLATURE

The legislators departed Lansing, October 15th for 1965. They had considered the establishment of an osteopathic college authority; even passed a bill in one house but thought better of it in the other, and called the proposal off this year. But it will be back next year. It's amazing how many factors are involved in the consideration of the problem of medical education in Michigan. Unfortunately, the less a legislator knows the more prone he is to act quickly. Incidentally, it's no secret that many, many osteopaths don't want an osteopathic college in Michigan. In fact, are downright opposed to it. But some of them are afraid to say so.

A TOAST

God bless the ladies of the Woman's Auxiliary. When asked to help man the Healthmobile they responded enthusiastically. It wasn't long after the girls arrived to take over that they were giving out with spiels that would have done credit to yesterday's "medicine man."

MEDICAL INFO ON LICENSES

The MSMS House of Delegates recommended that medical information, particularly regarding tetanus immunization, be placed on Michigan drivers' licenses. We worked with Secretary of State Hare and a gummed sticker was officially approved and designed to be affixed along the bottom edge of the back of the new drivers' licenses. MSMS purchased 1,000,000 stickers.

SERVING YOU

Lots of doctors have been serving you. Many have been doing things you may not have heard about. For example, listed below are some of the doctors who have given their time and thought in your behalf—many times at a financial sacrifice. They have appeared on radio and television respectively, bringing credit to their profession and serving the public interest.

Radio:

George E. Bacon, M.D.
Inta Ertel, M.D.
George H. Lowrey, M.D.
George W. Morley, M.D.
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Michigan State Medical Society Directory

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This Directory lists the membership of each component medical society and therefore the total membership of the Michigan State Medical Society. For more effective reference use, the directory also contains an alphabetical list of all MSMS members, with a reference to both the page number and the county society code number.

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East Lansing, Michigan
Phone 517/337-1351

Detroit Office:
Michigan State Medical Society
1010 Antietam
Detroit, Michigan
Phone 313/965-0541

The Michigan State Medical Society . . .

—**Presents** postgraduate training programs, available to all members, by means of the annual meeting, regional conferences and lectures at county medical societies;

—**Conducts** public service projects in preventive medicine, maternal health and many other fields;

—**Provides** a way for the members of the medical profession in Michigan to unite and take action on matters affecting public health and the practice of medicine;

—**Provides** advice and guidance to official and voluntary agencies and organizations participating in medical and health activities;

—**Presents** the medical profession of Michigan through an active legislative program, both State and National, by presenting the views and opinions of the membership to these governments, and by keeping the membership informed on developments and actions on legislative matters;

—**Serves** as a clearing house for information to members of the profession;

—**Conducts** an active public relations program including the distribution of prepared literature, the furnishing of articles and material to the press, and presenting programs over radio and television stations;

—**Sponsors** six state-wide group insurance plans: Sickness and Accident, Professional Liability, Major Hospital, Business Overhead, Savings and Retirement and Accidental Death, Dismemberment, and Disability;

—**Publishes** the Michigan Medicine, official organ of the Society; Medigram, a supplementary newsletter published quickly whenever there is a need to inform the membership.

Guide to Help Locate Cities within the Counties

This guide matches up the counties for all Michigan communities of 1,000 population or more.*

CITY and COUNTY

Adrian (Lenawee)
Albion (Calhoun)
Algonac (St. Clair)
Allegan (Allegan)
Alma (Gratiot)
Almont (Lapeer)
Alpena (Alpena)
Ann Arbor (Washtenaw)

Bad Axe (Huron)
Bangor (Van Buren)
Battle Creek (Calhoun)
Bay City (Bay)
Belding (Ionia)
Belleville (Wayne)
Bellevue (Eaton)
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Berkley (Oakland)
Berrien Springs (Berrien)
Bessemer (Gogebic)
Big Rapids (Mecosta)
Birmingham (Oakland)
Blissfield (Lenawee)
Bloomfield Hills (Oakland)
Boyne City (Charlevoix)
Brighton (Livingston)
Bronson (Branch)
Brookline (Jackson)
Buchanan (Berrien)

Cadillac (Wexford)
Calumet (Houghton)
Capac (St. Clair)
Carleton (Monroe)
Caro (Tuscola)
Carson City (Montcalm)
Cass City (Tuscola)
Cassopolis (Cass)
Cedar Springs (Kent)
Center Line (Macomb)
Charlevoix (Charlevoix)
Charlotte (Eaton)
Cheboygan (Cheboygan)
Chelsea (Washtenaw)
Chesaning (Saginaw)
Clare (Clare)
Clawson (Oakland)

CITY and COUNTY

Clinton (Lenawee)
Clio (Genesee)
Coldwater (Branch)
Coloma (Berrien)
Colon (St. Joseph)
Constantine (St. Joseph)
Coopersville (Kent)
Corunna (Shiawassee)
Croswell (Sanilac)

Davison (Genesee)
Dearborn (Wayne)
Decatur (Van Buren)
Detroit (Wayne)
Dexter (Washtenaw)
Dowagiac (Cass)
Dundee (Monroe)
Durand (Shiawassee)

East Ann Arbor (Washtenaw)
East Detroit (Macomb)
East Grand Rapids (Kent)
East Jordan (Charlevoix)
East Lansing (Ingham)
East Tawas (Iosco)
Eaton Rapids (Eaton)
Ecorse (Wayne)
Escanaba (Delta)
Essexville (Bay)
Evart (Osceola)

Farmington (Oakland)
Fenton (Genesee)
Ferndale (Oakland)
Flat Rock (Wayne)
Flint (Genesee)
Flushing (Genesee)
Fowlerville (Livingston)
Frankenmuth (Saginaw)
Frankfort (Benzie)
Fraser (Macomb)
Fremont (Newaygo)

Galesburg (Kalamazoo)
Garden City (Wayne)
Gaylord (Otsego)
Gladstone (Delta)

CITY and COUNTY

Gladwin (Gladwin)
Grand Haven (Ottawa)
Grand Ledge (Eaton)
Grand Rapids (Kent)
Grandville (Kent)
Grayling (Crawford)
Greenville (Montcalm)
Grosse Pointe (Wayne)
Grosse Pointe Farms (Wayne)
Grosse Pointe Park (Wayne)
Grosse Pointe Shores (Wayne & Macomb)
Grosse Pointe Woods (Wayne & Macomb)

Hamtramck (Wayne)
Hancock (Houghton)
Harbor Beach (Huron)
Harbor Springs (Emmet)
Hart (Oceana)
Hartford (Van Buren)
Hastings (Barry)
Hazel Park (Oakland)
Highland Park (Wayne)
Hillsdale (Hillsdale)
Holland (Ottawa)
Holly (Oakland)
Homer (Calhoun)
Houghton (Houghton)
Howell (Livingston)
Hubbell (Houghton)
Hudson (Lenawee)
Hudsonville (Ottawa)
Huntington Woods (Oakland)

Imlay City (Lapeer)
Inkster (Wayne)
Ionia (Ionia)
Iron Mountain (Dickinson)
Iron River (Iron)
Ironwood (Gogebic)
Ishpeming (Marquette)
Ithaca (Gratiot)

Jackson (Jackson)
Jonesville (Hillsdale)

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*See page 1 for Index by counties.

CITY and COUNTY

Kalamazoo (Kalamazoo)
Kalkaska (Kalkaska)
Kingsford (Dickinson)

Lake Linden (Houghton)
Lake Odessa (Ionia)
Lake Orion (Oakland)
L'Anse (Baraga)
Lansing (Ingham)
Lapeer (Lapeer)
Laurium (Houghton)
Lawton (Van Buren)
Leslie (Ingham)
Lincoln Park (Wayne)
Livonia (Wayne)
Ludington (Mason)

Mancelona (Antrim)
Manchester (Washtenaw)
Manistee (Manistee)
Manistique (Schoolcraft)
Manton (Wexford)
Marcellus (Cass)
Marine City (St. Clair)
Marlette (Sanilac)
Marquette (Marquette)
Marshall (Calhoun)
Marysville (St. Clair)
Mason (Ingham)
Melvindale (Wayne)
Menominee (Menominee)
Michigan Center (Jackson)
Middleville (Barry)
Midland (Midland)
Milan (Monroe & Washtenaw)
Milford (Oakland)
Millington (Tuscola)
Monroe (Monroe)
Montague (Muskegon)
Morenci (Lenawee)
Mount Clemens (Macomb)
Mount Morris (Genesee)
Mount Pleasant (Isabella)
Munising (Alger)
Muskegon (Muskegon)
Muskegon Heights (Muskegon)

Nashville (Barry)
Negaunee (Marquette)
Newaygo (Newaygo)
New Baltimore (Macomb & St. Clair)
Newberry (Luce)
New Buffalo (Berrien)

CITY and COUNTY

Niles (Berrien)
North Muskegon (Muskegon)
Northville (Wayne & Oakland)
Norway (Dickinson)

Oak Park (Oakland)
Onaway (Presque Isle)
Ontonagon (Ontonagon)
Otsego (Allegan)
Ovid (Clinton)
Owosso (Shiawassee)
Oxford (Oakland)

Painesdale (Houghton)
Parchment (Kalamazoo)
Paw Paw (Van Buren)
Pentwater (Oceana)
Perry (Shiawassee)
Petersburg (Monroe)
Petoskey (Emmett)
Pigeon (Huron)
Pinconning (Bay)
Plainwell (Allegan)
Pleasant Ridge (Oakland)
Plymouth (Wayne)
Pontiac (Oakland)
Port Huron (St. Clair)
Portland (Ionia)

Quincy (Branch)

Reading (Hillsdale)
Reed City (Osceola)
Richmond (Macomb)
River Rouge (Wayne)
Riverview (Wayne)
Rochester (Oakland)
Rockford (Kent)
Rockwood (Wayne)
Rogers City (Presque Isle)
Romeo (Macomb)
Roseville (Macomb)
Royal Oak (Oakland)

Saginaw (Saginaw)
Saint Clair (St. Clair)
Saint Clair Shores (Macomb)
Saint Ignace (Mackinac)
Saint Johns (Clinton)
Saint Joseph (Berrien)
Saint Louis (Gratiot)
Saline (Washtenaw)
Sandusky (Sanilac)

CITY and COUNTY

Saugatuck (Allegan)
Sault Sainte Marie (Chippewa)
Schoolcraft (Kalamazoo)
Scottville (Mason)
Sebewaing (Huron)
Shelby (Oceana)
Southfield (Wayne)
South Haven (Van Buren)
South Lyon (Oakland)
Sparta (Kent)
Spring Lake (Ottawa)
Stambaugh (Iron)
Standish (Arenac)
Stanton (Montcalm)
Stockbridge (Ingham)
Sturgis (St. Joseph)
Sylvan Lake (Oakland)

Tawas City (Iosco)
Tecumseh (Lenawee)
Three Rivers (St. Joseph)
Traverse City (Grand Traverse)
Trenton (Wayne)

Union City (Branch & Calhoun)
Utica (Macomb)

Vandercook Lake (Jackson)
Van Dyke (Macomb)
Vassar (Tuscola)
Vicksburg (Kalamazoo)

Wakefield (Gogebic)
Walled Lake (Oakland)
Warren (Macomb)
Watervliet (Berrien)
Wayland (Allegan)
Wayne (Wayne)
West Branch (Ogemaw)
Whitehall (Muskegon)
White Pigeon (St. Joseph)
Wyandotte (Wayne)
Wyoming (Kent)

Yale (St. Clair)
Ypsilanti (Washtenaw)

Zeeland (Ottawa)

Directory, Listed by Component Medical Societies

Special Memberships are indicated as follows: "L" for Life Members; "M" for Military Members; "N" for Non-Resident Members; "R" for Retired Members; "A" for Associate Members; all others are Active Members (Numbers in parentheses indicate County Society Code Numbers used in the Alphabetical Roster.)

ALLEGAN COUNTY MEDICAL SOCIETY (10)

Brachman, A. Peter, Jr............222 Trowbridge St., Allegan
Brown, Lewis F............133 E. Allegan St., Otsego
Chase, Walter E............137½ N. Main St., Plainwell
Clark, James I............Box B, Fennville
Everett, D. W. ....Plainwell Sanitarium, Plainwell
Goddard, G. B............218 E. Orleans, Otsego
Goude, Albert G. (A)............Ahoada Co. Hospital, Ahoada, East Nigeria, West Africa
Hays, James D............Douglas
Johnson, Elwin B............144 Brady St., Allegan
Johnson, Harrison H. (L)............Wayland
Keeler, Van O............Otsego
Mahan, James E............402 Trowbridge St., Allegan
Medill, Wilbur C............139 N. Main St., Plainwell
Miller, Kenneth C............Saugatuck
Mitchell, Abbott B............County Health Dept., Allegan
Pone, Janis............Martin
Ramseyer, Gladwin E............125 E. Bridge, Plainwell
Schneiter, Harry E............425 Cutler St., Allegan
Schock, William H............315 Maple St., Saugatuck
Topp, E. Robert............2402 West B Ave., Plainwell
Topp, Elwin W............502 N. Main St., Plainwell
Van Der Kolk, Bert............Hopkins
Vander Voord, Gerald............312 E. Plum St., Wayland
Vaughan, Willard R. (L)............Plainwell
Wiseman, Bertha A............Box 177, Allegan

ALPENA-ALCONA-PRESQUE ISLE COUNTY MEDICAL SOCIETY (14)

Aliferis, Peter............Alpena General Hosp., Alpena
Arscott, Edward F............Rogers City
Brown, Donald C............312 E. Chisholm St., Alpena
Bunting, John W............110 N. 1st Ave., Alpena
Burkholder, H. J. (L)............122 N. Second Ave., Alpena
Cohn, Stuart L............1253 W. Washington, Alpena
Constantine, Aeneas............Harrisville
Finch, Donald E............Onaway
Foley, Richard............Rogers City
Fox, William L............601 W. Chisholm St., Alpena
Grause, Thomas J............312 E. Chisholm St., Alpena
Hier, Edward A............125 N. Second Ave., Alpena
Jackson, Wm. F............Rogers City
Kessler, Harold (A)............312 E. Chisholm St., Alpena
Kutsche, W. F............208 Lake St., Oscoda
Lepard, J. M............312 E. Chisholm, Alpena
Lipski, John G. (A)......Traverse State Hosp., Traverse City
Nesbitt, Wm. E............123 N. 2nd Ave., Alpena
Newman, Roy E............Alpena General Hosp., Alpena
O'Dell, F. C., Jr............110 W. Chisholm St., Alpena
Parmenter, Elbert S. (L)............Box 192, Alpena
Philippon, Carlos A............312 E. Chisholm St., Alpena
Ramsey, J. Allen............312 E. Chisholm, Alpena
Ries, Robt. C............Rogers City
Riker, John L............303 N. Second Ave., Alpena
Rowell, Wilfred J............Alpena Gen. Hosp., Alpena
Spens, James E............123 N. Second Ave., Alpena
Stump, G. D............123 N. Second, Alpena
Wagoner, Darwin E............5007 N. Cedar Lake Rd., Oscoda
Watkins, T. M............312 E. Chisholm St., Alpena
Wienczewski, T. W............919 N. Second Ave., Alpena
Wilson, Chas. S. (L)............730 State Ave., Alpena

BARRY COUNTY MEDICAL SOCIETY (18)

Birk, Wilbur R............110 W. Center, Hastings
Blair, Larry............110 W. Center, Hastings
Brown, Jack A............303 Broadway, Middleville
Castleman, Douglas H............110 W. Center, Hastings
Finnie, Gordon M............535 E. Francis, Hastings
Finnie, R. G............535 E. Francis, Hastings
Gwinn, Alexander B............118 E. Walnut, Hastings
Heaslip, Jos. D. (R)......13800 83rd Place N., Largo, Florida
Huebner, R. J............110 W. Center, Hastings
Lofdahl, Stewart (R)............Rt. 1, Box 172, St. Charles, Ill.
Logan, Wesley G............City Bank Bldg., Hastings
Lundeen, John G............595 Jordon Lake, Lake Odessa
Morrill, Charles E............400 W. State St., Hastings
Myers, Thos. W............307 N. Main St., Nashville
Noah, Melvin L............Middleville
Phelps, Everett L............535 E. Francis St., Hastings
Pryor, Robt B............400 W. State St., Hastings
Tromp, Jack L............Rt. 3, Lake Odessa
Wedel, Herbert S............110 W. Center, Hastings

BAY-ARENAC-IOSCO COUNTY MEDICAL SOCIETY (22)

Alcorn, Kent A..........1420 Center Ave., Bay City
Alcorn, Marshall W..........1420 Center Ave., Bay City
Allen, Arthur D..........101 W. John St., Bay City
Antle, Robert C..........101 W. John St., Bay City
Asbury, Richard B..........2110 16th St., Bay City
Asline, John N..........207 N. Walnut St., Bay City
Austin, Justus J. (R)..........Tawas City
Bowman, David A..........101 W. John St., Bay City
Bozdech, Jiri Josef..........900 N. Jackson, Bay City
Brenner, Frederick..........900 N. Jackson, Bay City
Brinkman, Harvey H..........116 W. State St., East Tawas
Brown, Geo. M..........207 N. Walnut St., Bay City
Campbell, Donald A..........700 Borton, Essexville
Campbell, John S..........1833 McKinley Ave., Bay City
Chapin, Fredk. J..........2121 Center Ave., Bay City
Cook, Hugh K..........101 W. John St., Bay City
Cook, Raymond R..........1115 Fifth St., Bay City
Cooper, James C..........705 Oak St., Essexville
Cosens, Stanley A..........101 W. John St., Bay City
Crissey, Robt. R..........101 W. John St., Bay City
Criswell, Robt. H..........721 Washington Ave., Bay City
Csonka, Nicholas..........1308 Columbus Ave., Bay City
Dardas, Michael J..........1413 Center Ave., Bay City
Davis, James H. (A)..........1308 Columbus, Bay City
Dolbee, Malcolm K..........Box 518, Standish
Ellison, Alfred, Jr..........101 John St., Bay City
Ferguson, Robert..........101 W. John St., Bay City
Fischer, Hans..........Standish
Follis, Wm. M..........101 W. John, Bay City
Gamble, Wm. G., Jr..........2010 5th Ave., Bay City
Gehman, J. R..........Standish
Geneczko, John T..........1102 Columbus Ave., Bay City
Grigg, John W..........2110 Sixteenth St., Bay City
Hafford, Robert C..........101 W. John St., Bay City
Hagelshaw, Gayland L..........101 W. John St., Bay City
Hess, Chas. L. (R)..........305 Leonard Lane, Midland
Heuser, Harold H..........916 Washington Ave., Bay City
Hickner, Lawrence P..........101 W. John St., Bay City
Horowitz, Saml. F..........1415 Center Ave., Bay City
Howland, Walter L..........P.O. Box 633, Pinconning
Huckins, Rodger S..........1802 Broadway, Bay City
Jacques, J. E..........Tawas City
Jaffe, Martin D..........2110 16th St., Bay City
Jankowska, R. L..........2110 16th St., Bay City
Johnson, Orlen J. (L)..........207 N. Walnut St., Bay City
Jones, M. Culver..........900 N Jackson, Bay City
Jones, Tyre K., III..........1639 Carla Ct., Essexville
Kelly, Larry Stanley..........Tawas City
Kessler, Mana..........311 Center Ave., Bay City
Kessler, Sabina (Frux)..........311 Center Ave., Bay City
Knobloch, Howard T..........1102 Columbus, Bay City
Kovacsi, Laszlo..........820 N. Johnson, Bay City
Krug, E. G..........Ohio State University, Columbus, Ohio
Kulinski, Eugene J..........2110 16th St., Bay City
Langin, John L..........100 15th St., Bay City
Loree, Joseph..........1407 Center Ave., Bay City
MacRae, Leonard D..........813 Sherman St., Bay City
Mayne, John C..........101 W. John St., Bay City
McGee, Harry B..........101 W. John, Bay City
McGee, Peter L..........2110 16th St., Bay City
McSherry, Leo B., Jr..........1102 Columbus Ave., Bay City
Medvezky, Michael J..........1106 S. Madison Ave., Bay City
Miller, Edwin C..........101 W. John St., Bay City
Moeller, Arlyn..........700 Borton Ave., Essexville
Moore, Allen B..........700 Borton Ave., Essexville
Moore, Neal R..........704 N. Jackson, Bay City
Mosier, Dwight J..........101 W John St., Bay City
Nixon, Robert S..........101 W. John St., Bay City
Parks, Floyd R., Jr..........101 W. John St., Bay City
Payea, Norman P..........217 Newman St., East Tawas
Pearson, Stanley M..........101 W. John St., Bay City
Pelczar, Walter E..........321 N. Johnson St., Bay City
Prophater, Robt. C..........202 Boehringer Ct., Bay City
Reidinger, Alan A..........700 Borton St., Essexville
Rodda, E. H..........101 W. John St., Bay City
Rogers, Charles S..........101 W. John St., Bay City
Rowe, Paul W..........Mercy Hospital, Bay City
Schmelzer, Wm. J..........602 Mercer St., P.O. 746, Pinconning
Shafer, Harold C..........101 W. John St., Bay City
Shields, Hubert L..........101 W. John St., Bay City
Staley, Hugh O..........Omer
Standiford, David..........2110 16th St., Bay City
Stroia, Livius N..........101 W. John St., Bay City
Sutton, R. L., Jr..........116 W. State St., East Tawas
Sweet, Irwin..........Gladwin
Taheri, Zia E..........1411 Center Ave., Bay City
Tarter, Clyde S. (R)..........Star Route, Alpena
Tompkins, Dana A..........Pinconning
Treadway, Gaylord..........900 N. Jackson, Bay City
Vail, Harry F..........1107 Columbus Ave., Bay City
Vanasupa, P..........101 W. John St., Bay City
Way, John H..........83 Cedar Dr., Bay City
Wilson, Thos. G. (R)..........Rt. 2, Box 112H, Tawas City
Woodburne, Harris L..........1420 Center St., Bay City
Wright, Thomas B..........101 W. John St., Bay City
Zaremba, Aloysius J. (L)..........108 S. Madison Ave., Bay City
Ziliak, Alois L., Jr..........3393 Kiesel Rd., Bay City

BERRIEN COUNTY MEDICAL SOCIETY (26)

Asselin, Dean R..........2817 S. State St., St. Joseph
Atkinson, Robert L..........1626 Langley Ave., St. Joseph
Bailey, John H..........2150 Samuel Ave., Benton Harbor
Beal, Gerald N..........Sheperd Benning Bldg., St. Joseph
Benner, Wm. H..........700 Empire Rd., Benton Harbor
Bieri, Dixon L..........645 Riverview Dr., Benton Harbor
Bliesmer, August F..........505 Pleasant St., St. Joseph
Brink, John W..........811 Myrtle St., St. Joseph
Bronfenbrenner, Jack..........687 E. Empire Ave., Benton Harbor
Bruni, John R..........1 South Fifth St., Niles
Camp, Donald C..........8 N. St. Joseph Ave., Niles
Carter, John H..........687 E. Empire Ave., Benton Harbor
Cawthorne, Harold J. (R)..........Rt. 4, Box 201, Coloma
Chickering, Wm. A..........205 E. Delaware St., Benton Harbor
Cilella, S. G..........Pawating Hospital, Niles
Colligan, Joseph (A)..........University Hospital, Ann Arbor
Conway, Jos..........Watervliet
Conybeare, Robt. C..........756 Pipestone, Benton Harbor
Cooke, Weldon..........Berrien County Hosp., Berrien Center
Cooper, Wm. L..........Rt. 1, Paw Paw Island, Coloma
Crowell, Richard C..........645 Riverview Dr., Benton Harbor
Dailey, Walter S..........122 Grant St., Niles
Dalgleish, Archie J..........460 N Main St., Watervliet
Doolittle, John E..........95 St. Joseph Ave., Niles
Eidson, Hazel D. (L)..........Berrien Springs
Elghammer, Richard M..........1106 Highland Ave., St. Joseph
Elliott, J. Colin..........802 E. Front St., Buchanan
Emery, Clayton S. (L)..........1020 Niles Ave., St. Joseph
Emery, Wm. K..........1020 Niles Ave., St. Joseph
Faber, Michael..........756 Pipestone St., Benton Harbor
Fattic, Grover R., Jr..........61 N. St. Joseph Ave., Niles
Feeley, Marshall J..........2516 Niles Ave., St. Joseph
Friedman, Morris E..........Barton St., New Buffalo
Galles, James O..........275 Paw Paw Ave., Coloma
Garrett, Evan L..........61 N. St. Joseph Ave., Niles
Gillette, Clarence (L)..........R.F.D. 4, M 60 W., Niles
Gonzalez, C. G..........2821 Sunnydale, St. Joseph
Gould, Samuel H..........1850 Colfax Ave., Benton Harbor
Grayson, Chas. J..........4 Maple St., Three Oaks
Green, Barbara G..........2600 Morton St., St. Joseph
Green, Robt. L..........2600 Morton St., St. Joseph
Grundset, Harold M..........61 N. St. Joseph Ave., Niles
Guaty, Nestor C..........858 Pipestone St., Benton Harbor
Hassan, D. Kent..........802 E. Front St., Buchanan
Haupt, Edward C..........687 E. Empire, Benton Harbor
Hayes, Thos. P..........2821 State St., St. Joseph
Henderson, Fred C..........703 E. Main, Niles
Hershey, Noel J..........P.O. Box 222, Niles
Hills, David W..........2821 State St., St. Joseph
Howard, Frank W..........756 Pipestone, Benton Harbor
Hudnutt, Dean..........811 Myrtle St., St. Joseph
Huff, Harold D..........126 Main St., Niles
Irgens, Edwin R..........11 Peoples St. Bk. Bldg., St. Joseph
Jochems, Dirk G..........802 E. Front St., Buchanan
Johnston, Wm. H..........2522 Niles Ave., St. Joseph

Kelsall, Harvey I..........1600 Niles Ave., St. Joseph
Kenfield, W. J..........505 Pleasant St., St. Joseph
Kennedy, F. Alan..........315 Fidelity Bldg., Benton Harbor
Kilic, Orhan..........1060 Allouez Dr., Niles
King, Frank A., Jr..........858 Union St., Benton Harbor
Klos, Henry J..........2700 Highland Ct., St. Joseph
Landgraf, Robt. L..........P.O. Box 222, Niles
Learned, David W..........645 Riverview Dr., Benton Harbor
Lee, Hai Soon..........711 Beechwood Dr., Niles
Leva, John B..........1122 Salem Ave., Benton Harbor
Lindenfeld, Fredk. H..........8 N. St. Joseph Ave., Niles
Lininger, Richard E..........2712 Highland Ct., St. Joseph
Linn, Frank..........2522 Niles, St. Joseph
Locey, Robert P..........164 Higman Park Rd., Benton Harbor
Macias, Raphael..........8 N. St. Joseph Ave., Niles
Manning, John T..........1150 Miami Rd., Benton Harbor
McLelland, J. T...Mercy Hosp. X-Ray Dept., Benton Harbor
Mesirow, Stanley M..........687 E. Empire Ave, Benton Harbor
Moore, T. Scott..........P.O. Box 416, Niles
Namtze, Chan..........1111 Oak St., Niles
O'Toole, John..........133 E. Napier, Benton Harbor
Ozeran, Chas. J..........127 E. Napier, Benton Harbor
Padelford, Wm. J..........South Lyon
Payne, Charles E..........925 Pipestone St., Benton Harbor
Peshka, David K..........61 N. St. Joseph Ave., Niles
Polansky, Sanford..........84 W. Main St., Benton Harbor
Porter, Chas. B..........1589 Colfax Ave., Benton Harbor
Pritchard, Harold M..........502 Broadway, Niles
Qadir, Syed A..........113 N. Portage, Buchanan
Rague, Paul O..........960 Agard, Benton Harbor
Rambo, Joseph J..........505 Lake St., Bridgeman
Ray, Dean K..........2522 Niles, St. Joseph
Reagan, Robt. E..........232 Windsor, Benton Harbor
Ruth, J. Griswold..........507 Britain Ave., Benton Harbor
Skinner, James W..........460 Ridgeway St., St. Joseph
Smith, W. B..........133 E. Napier, Benton Harbor
Sori, Manuel R..........858 Pipestone St., Benton Harbor
Sowers, Bouton F. (A)..........236 Higman Park, Benton Harbor
Strayer, John W..........P.O. Box 222, Niles
Stulik, Chas. K. (L)..........Town Line Rd., P.O. Box 98, Union Pier
Turner, John J..........2817 S. State St., St. Joseph
Urist, Maurice D..........454 Pipestone St., Benton Harbor
Valantiejus, John A.....Rt. 2, Cedar Lane Farm, New Buffalo
Vasquez, Andres H..........Chikaming Medical Ctr., Harbert
Vastine, Russell J., Jr..........430 W. Chicago, Buchanan
Watkins, Richard W. (L)..........131 E. Napier, Benton Harbor
Westervelt, H. O. (L)..........539 Pearl St., Benton Harbor
Willson, Dean..........756 Pipestone, Benton Harbor
Wilson, Clinton W..........925 Pipestone St., Benton Harbor
Woodford, Hackley E..........599 E. Main, Benton Harbor
Zick, Luther H..........2522 Niles Ave., St. Joseph

BRANCH COUNTY MEDICAL SOCIETY (30)

Aldrich, Napier S..........162 Marshall St., Coldwater
Bacon, Charles R..........300 E. Chicago St., Coldwater
Bailey, James E., Jr..........300 E. Chicago St., Coldwater
Beatty, James B..........300 E. Chicago St., Coldwater
Bien, Walter W. J. (L)..........65 N. Monroe St., Coldwater
Burke, James M..........40 Balfour Dr., Coldwater
Coates, Carl A..........135 Stringtown, Rt. 1, Quincy
Culver, Dean T..........173 E. Chicago St., Coldwater
Fraser, Robt. J..........22 W. Pearl St., Coldwater
Geib, Ormond D..........State Home Trng. School, Coldwater
Gomley, Henry C..........108 E. Chicago St., Bronson
Heffelfinger, John C..........292 E. Chicago St., Coldwater
Hoeksema, Ronald H..........292 E. Chicago St., Coldwater
Leitch, Robt. M..........401 Ann St., Union City
Meier, Harold J. (L)..........87 W. Pearl St., Coldwater
Mooi, Henry R..........292 E. Chicago St., Coldwater
Moss, Harvey L..........47 Carlyle, Coldwater
Nettleman, Wm. E..........87 W. Pearl St., Coldwater
Olmsted, Kenneth L..........675 Monroe, Coldwater
Rennell, Edwin J..........Coldwater State Home, Coldwater
Rick, John J..........61 E. Chicago St., Coldwater
Stewart, William K..........403 Ann St., Union City
Thomas, James A..........390 E. Chicago St., Coldwater
Walton, Nathaniel J..........Box 148, Coldwater
Weidner, Harold R..........50 Division St., Coldwater
Wise, Robert..........State H.M. & Trng. School, Coldwater

CALHOUN COUNTY MEDICAL SOCIETY (34)

Agin, L. J. (A)..........VA Hospital, Battle Creek
Albright, Arnold A..........R 1, Box 300, Battle Creek
Allen, R. H..........191 College, Battle Creek
Amos, Norman H..........710 North Ave., Battle Creek
Amos, Norman O..........710 North Ave., Battle Creek
Anderson, Harold E..........65 W. Michigan Ave., Battle Creek
Arnold, George K. (A)..........VA Hospital, Ft. Custer
Azuela, Victor..........185 N. Washington, Battle Creek
Bakken, Richard L..........200 College St., Battle Creek
Barden, Stuart P..........Leila Hosp., Battle Creek
Baribeau, Roy H. (L)....65 W. Michigan Ave., Battle Creek
Becker, Harry F. (L)..........Box 547, Battle Creek
Berghorst, John (A)..........VA Hospital, Battle Creek
Bodine, Harold R..........231 North Ave., Battle Creek
Bonifer, Philip P., Jr...401 Security Bk. Bldg., Battle Creek
Bonifer, Philip P..........231 North Ave. Battle Creek
Boswell, David E..........105 N. Jefferson Ave., Marshall
Brainard, C. W. (L)..........148 Wahwah Tay See Way, Battle Creek
Brown, Robt. W..........231 North Ave., Battle Creek
Buell, Martin F. (A)..........VA Hospital, Ft. Custer
Campbell, Alice F..........103 E. Mulberry St., Albion
Campbell, Jack S..........1018 North Ave., Battle Creek
Campbell, Richard J.....140 Capital Ave. N.E., Battle Creek
Capron, M. J., Jr..........806 Security Bk. Bldg., Battle Creek
Caviness, L. Harold..........185 N. Washington, Battle Creek
Chandler, Edward M..........411 Mich. Nat. Bk. Bldg., Battle Creek
Chynoweth, Wm. R. (L)..........207 Post Bldg., Battle Creek
Coakes, Jack E..........112 W. Mansion, Marshall
Colquhoun, Graham F..........188 College St., Battle Creek
Cram, Ralph A..........500 S. Ionia St., Albion
Curry, Robt. K..........Homer
Daly, Harold L., Jr..........500 S. Ionia St., Albion
Daly, Mary..........201 River St., Albion
Daly, Miriam S..........500 S. Ionia St., Albion
Diamante, Paul J..........710 North Ave., Battle Creek
Dickson, Albert R. (L)..........250 Champion St., Battle Creek
Dodge, Warren M., Jr..........1207 Wolverine Tower, Battle Creek
Fairbanks, Stephen..........306 S. Superior, Albion
Ferazzi, Patrick S..........1018 North Ave., Battle Creek
Finch, Duward L..........719 Capital Ave. S.W., Battle Creek
Fisher, Robt. E..........1501 W. Michigan Ave., Battle Creek
Fraser, Robt. H. (L)......25 W. Michigan Ave., Battle Creek
Funk, L. D..........133 W. Burr Oak, Athens
Gething, Jos. W. (L)....538 W. Michigan Ave., Battle Creek
Giddings, A. M. (L)..........103 Dieker Pl., St. Marys, Ohio
Gieser, E. Paul, Jr..........407 Alton, Battle Creek
Gilfillan, Margery J. (L)..........125 56th Ave. S., St. Petersburg, Fla.
Girardot, John G..........25 W. Michigan, Battle Creek
Glotfelty, Philip R..........219 N. Madison, Marshall
Gough, Joseph G.....American Legion Hospital, Battle Creek
Graubner, Franklin L..........Bogar Theater Bldg., Marshall
Gray, J. Alan..........309 Mich. Natl. Bk. Bldg., Battle Creek
Griffith, Jack C..........616 Mich. Natl. Bk. Bldg., Battle Creek
Hamady, Alfred..........1018 North Ave., Battle Creek
Hansen, Edwin L..........216 North Ave., Battle Creek
Hansen, Harvey C..........65 W. Michigan Ave., Battle Creek
Henderson, Philip M..........109 W. Erie, Albion
Henriksen, J. D..........4 Hiawatha, Battle Creek
Hibbs, Donald K..........117 Sunnyside Dr., Battle Creek
Holtom, Benj. G..........815 Security Tower, Battle Creek

Hooker, Lyle T. (A)....................VA Hospital, Battle Creek
Hubly, James W.........1509 Security Natl. Bk., Battle Creek
Humphrey, Archie E.............864 E. Michigan St., Marshall
Humphrey, Arthur A...............175 College St., Battle Creek
Humphrey, Herbert E.............122 N. Madison St., Marshall
Huntington, John....................710 North Ave., Battle Creek
Jeffrey, James R. (L)....................179 N. Washington Ave., Battle Creek
Jones, Aubrey H. (A)........................VA Hospital, Ft. Custer
Jones, Ernest F. (A)................175 Island Ave., Battle Creek
Jones, Tyre K..................................118 W. Green, Marshall
Keeler, Kenneth B. (R)..................417 Elizabeth St., Albion
Kelleher, Geo. T.......................235 North Ave., Battle Creek
Kimball, Arthur S., Jr.........1150 E. Michigan, Battle Creek
Kinde, Matthew R...................250 Champion, Battle Creek
Kingsley, Paul C..........................191 College, Battle Creek
Klopp, Edward J.....................173 College St., Battle Creek
Knode, Robert Edwin (A)............2221 S. Circle, Ann Arbor
Ladrew, Frederick (A)..................VA Hospital, Battle Creek
Lakke, Gordon W.....................163 North Ave., Battle Creek
Lam, Francis L...........408 Capital Ave. S.W., Battle Creek
Lancaster, Vance B.................710 North Ave., Battle Creek
Levy, Elizabeth H. (A)...................145 Fuller Rd., Box 42, Battle Creek
Levy, Jos., Jr.............................231 North Ave., Battle Creek
Lewis, Welcome B. (L)..196 Irving Park Dr., Battle Creek
Long, Walter B..Homer
Lowe, Kenneth H...................231 North Ave., Battle Creek
Lowe, Stanley T. (R)..............231 North Ave., Battle Creek
Lund, C. A. E.......................135 Hamblin Ave., Battle Creek
Mauer, James J...........................616 Mich. Nat'l Bank Bldg., Battle Creek
McCuaig, Alfred G.......719 Capitol St. S.W., Battle Creek
McGee, John W................................105 Irwin Ave., Albion
Melges, Fredk. J.............25 W. Michigan Ave., Battle Creek
Mitton, Orland W. (R)........................9026 Clairmont N.E., Albuquerque, N. Mex.
Morrison, Donald B.............719 Capital S.W., Battle Creek
Mullenmeister, H. F.............275 Capital N.E., Battle Creek
Murillo, Casmir......................235 North Ave., Battle Creek
Norgan, Anne F.........719 Capital Ave S.W., Battle Creek
Parkinson, Chas. E...................Leila Hospital, Battle Creek
Patrick, Gilbert T...........25 W. Michigan Ave., Battle Creek
Pearson, Donald J...................255 North Ave., Battle Creek
Pier, Clarence T. (A)..................VA Hospital, Battle Creek
Powell, C. E.............................632 North Ave., Battle Creek
Powell, Donna (A)..........................VA Hospital, Ft. Custer
Power, John R.............140 Capital Ave. N.E., Battle Creek
Reizner, Bernard Z.....................Oaklawn Hospital, Marshall
Robbert, John.................................191 College, Battle Creek
Roberge, Jerome T...1407 Security Bank Bldg., Battle Creek
Rorich, Wilma C. W. (R)....166 N.E. Capital, Battle Creek
Rowan, Russell C...............................500 S. Ionia St., Albion
Royer, Clark W.........1331 W. Michigan Ave., Battle Creek
Ryan, Chas. J............................Leila Hospital, Battle Creek
Seifert, Charles (M)....6231 Peace Pipe, San Antonio, Texas
Sharp, Ara D. (R)..............................502 Irwin Ave., Albion
Shellenberger, H. M.....................123 S. Jefferson, Marshall
Shipp, Leland P...............25 W. Michigan Ave., Battle Creek
Sibilsky, A. Clark (A)...........106 Brewer Dr., Battle Creek
Simpson, Robt. S...........700 Capital Ave. S.W., Battle Creek
Slagle, Geo. W. (L)......203 Capital Ave. N.E., Battle Creek
Spencer, Collis M.....................308½ S. Superior St., Albion
Stadle, Wendall H. (R).......................607 Jennings Landing, Gougac Lake, Battle Creek
Stephenson, C. D...........140 Capital Ave. N.E., Battle Creek
Stiefel, Richard A.........25 W. Michigan Ave., Battle Creek
Strohmenger, Frank J.......................500 S. Ionia St., Albion
Taylor, Clifford B...............................500 S. Ionia St., Albion
Tazelaar, Myron A.................219 N. Madison St., Marshall
Thompson, Walter C.....Battle Creek Hlt. Ctr., Battle Creek
Vander Kamp, Harry (A)..........VA Hospital, Battle Creek
Vander Voort, Wm. V. (L)...........................Rt. 4, Hastings
Verity, Lloyd E.................1002 Security Tower, Battle Creek
Vetne, Gunnar........................725 Capital S.W., Battle Creek
Walker, Chas S.............709 W. Van Buren St., Battle Creek
Walters, John F.........................163 North Ave., Battle Creek
Walters, Wm. D.......................175 College St., Battle Creek
Wemmer, Keith S.......1472 W. Michigan Ave., Battle Creek
Wencke, Carl G. (L)................112 Brewer Dr., Battle Creek
Winslow, Sherwood B.............710 North Ave., Battle Creek
Worgess, Duane R.........799 Capital Ave. N.E., Battle Creek
Yannitelli, S. A.......................710 North Ave., Battle Creek
Young, John R.............719 Capital Ave. S.W., Battle Creek
Zaplitny, R. B............................163 North Ave., Battle Creek
Zaplitny, Sophia (A)..................R 3, Box G5A, Battle Creek
Zheutlin, Bertram........................50 Adams St., Battle Creek
Zindler, Geo. A.........1201 Security Bk. Bldg., Battle Creek

CASS COUNTY MEDICAL SOCIETY (38)

Adams, Uriah M...Marcellus
Clary, Rudolph I.........................216 S. Front St., Dowagiac
Comstock, L. David, Jr.................417 W. High St., Dowagiac
Guzzo, Henry V.....................110 W. Division St., Dowagiac
Hickman, John K...................108 W. Division St., Dowagiac
Loupee, Geo. E...................................114 West St., Dowagiac
Loupee, Sherman L. (L)....................108 Orchard, Dowagiac
Nakas, Osvaldes..R.R. 1, Cassopolis
Pierce, Frank L. (L)....................142 S. Front St., Dowagiac
Pierce, Kenneth C.......................417 W. High St., Dowagiac
Warren, Aaron K.............................109 School St., Cassopolis

CHIPPEWA-MACKINAC COUNTY MEDICAL SOCIETY (42)

Allott, Hugh R.............816 Ashmun Street, Sault Ste. Marie
Bandy, Festus C. (R)........2431 Hamlin Lane, Sarasota, Fla.
Blair, H. Milton..................300 Court St., Sault Ste. Marie
Clausen, Claire H.................300 Court St., Sault Ste. Marie
Coulter, Wm. J..Drummond Island
Finlayson, Donald D.......301 E. Spruce St., Sault Ste. Marie
Hagele, Marie A...................126 Park Pl., Sault Ste. Marie
Hamel, Herbert E...St. Ignace
Harrington, Harvey M. (L)........Box 319, Sault Ste. Marie
Heilman, Robert D.........War Mem. Hosp., Sault Ste. Marie
Howe, Donnell C., Jr...........300 Court St., Sault Ste. Marie
Mackie, Thos. B...................300 Court St., Sault Ste. Marie
McBryde, Lyman M.........416 Ashmun St., Sault Ste. Marie
Mertaugh, Wm. F.........104 W. Spruce St., Sault Ste. Marie
Montgomery, Benj. T.....812 Ashmun St., Sault Ste. Marie
Reddick, C. E.....................Chippewa County Health Dept., Sault Ste. Marie
Rhind, Earl S.....................Sault Polyclinic, Sault Ste. Marie
Scott, Dale........................816 Ashmun St., Sault Ste. Marie
Solomon, Joseph A...Mackinac Island
Thompson, Chas. F. (L)...........................Drummond Island
Trapasso, Tony J..................816 Ashmun, Sault Ste. Marie
Tygart, Robert L..................301 E. Spruce, Sault Ste. Marie
Venier, Anton G.............816 Ashmun St., Sault Ste. Marie
Wedding, Erling S...........203 Hudson Dr., Sault Ste. Marie

CLINTON COUNTY MEDICAL SOCIETY (46)

Bennett, Geo. W.................................203 W. Main St., Elsie
Cook, Bruno C...Westphalia
Elliott, Bruce R...Box 369, Ovid
Fillinger, Wells B. (L)...Ovid
Foo, Chas. T. (L).............1716 30th St. W., Bradenton, Fla.
Grost, James M...........................110 Oakland St., St. Johns
Henthorn, Arthur C. (L)..........................Box 216, St. Johns
Kelertas, Julius H....................................Parr Bldg., St. Johns
Russell, Sherwood R...............104 N. Oakland St., St. Johns
Scott, James S..De Witt
Sheline, Victor L...Medical Center, Ithaca
Slagh, Earl M...Elsie
Smith, Franklin W....................105 S. Ottawa St., St. Johns
Stephenson, Wesley F.................510 E. Walker St., St. Johns
Stoller, Paul F..St. Johns

DELTA-SCHOOLCRAFT COUNTY MEDICAL SOCIETY (50)

Anderson, Francis C......218 S. 10th St., Escanaba
Bernier, A. Barroso......547 Michigan Ave., Manistique
Bash, Theodore L......Bark River
Benson, Gilbert W. (A)......Ludington St., Escanaba
Boyce, Donald H......1107 Ludington St., Escanaba
Cretens, Mary......Delta Menominee Hth. Dept., Escanaba
Dehlin, James R......8 S. 11th St., Gladstone
Fitch, Donald N......804 Ludington St., Escanaba
Fyvie, James H......202 S. Cedar St., Manistique
Gordon, E. James......117 N. 22nd St., Escanaba
Groos, Harold Q......1015 S. 1st Ave., Escanaba
Groos, Louis P......1015 S. 1st Ave., Escanaba
Hockstad, Raymond ......804 Ludington St., Escanaba
Hult, Otto S......1005 Delta Ave., Gladstone
Le Mire, Donald F......1104 S. First Ave., Escanaba
Le Mire, William A......1106 First Ave. S., Escanaba
Lindquist, Norman L......205 S. Tenth St., Escanaba
Maniaci, Geo......8 South 11th St., Gladstone
McInerney, Thos. A......1221 Ludington St., Escanaba
Olson, Carl J......8 S. 11th St., Gladstone
Ryde, Robt. E......1221 Ludington, Escanaba
Theisen, Nikolaus J......1400 16th Ave. S., Escanaba
Waters, Duane L......200 S. Cedar St., Manistique
Wehner, Merle E......131 River St., Manistique
Whipple, Arno......117 North 22nd St., Escanaba

DICKINSON-IRON COUNTY MEDICAL SOCIETY (54)

Addison, Earl R......412 Superior Ave., Crystal Falls
Alexander, Wm. H......411 East C St., Iron Mountain
Anderson, Donald T......408 Hamilton Ave., Kingsford
Boyce, George H. (L)......First Natl. Bank Bldg., Iron Mountain
Carlson, Ralph E......500 Stephenson Ave., Iron Mountain
Cecconi, R. D......Commercial Bank Bldg., Iron Mountain
Cooper, Chas. A......Box 542, Stambaugh
Gendzwell, Joyce......805 Vulcan St., Iron Mountain
Gladstone, Wm. R., Jr......804 Main St., Norway
Hayes, Willard N......720 N. Main St., Norway
Huron, Willis H......106 West B St., Iron Mountain
Irvine, Lionel E......Box 438, Iron River
Jacobs, Donald J......Professional Bldg., Iron Mountain
Kofmehl, Wm. J......Stambaugh
McEachran, Hugh D......500 Stephenson Ave., Iron Mountain
Nora, James C......15 Eighth Ave., Iron River
Palm, E. T......Crystal Falls
Pieper, Ernest......Iron Mountain
Retallack, Russell C......326 W. Genesee St., Iron River
Schmutzler, Walter A......373 Woodward St., Iron Mountain
Schroeder, John M......Khoury Bldg., Iron Mountain
Smith, Donald R......Box 471, Iron Mountain
Steinke, Chas. G......517 Stephenson Ave., Iron Mountain
Stelle, Robert E......412 Superior, Crystal Falls
Trump, Paul L......808 Terrace, Kingsford
Wollum, Arnold (A)......R 1, Vulcan

EATON COUNTY MEDICAL SOCIETY (58)

Brown, Byron P......339 S. Cochran, Charlotte
Carothers, Danl. J......125 Lansing St., Charlotte
Curtis, Keith L......531 Foote St., Charlotte
De Land, C. Le Roy......Olivet
Erhard, O. Stewart......301 Rancho, Eaton Rapids
Garlock, Fred C......406 E. Jefferson St., Grand Ledge
Harrod, Gordon R......Grand Ledge
Joseph, Daniel D......R 1, Box 25, Charlotte
Matthews, R. W......236 S. Main St., Charlotte
Meinke, Albert H., Jr......702 S. Main, Eaton Rapids
Myers, Albert W......Potterville
Passos, Benjamin A......304 N. Cochran St., Charlotte
Riley, Jos. L......201 S. Cochran St., Charlotte
Robinson, S. R......1140 Willow St., Grand Ledge
Sevener, Lester G......236 S. Main St., Charlotte
Sherman, Eber B......P.O. Box 158, Eaton Rapids
Van Ark, Bert......511 Hale, Eaton Rapids
Van Ark, Herman F......Eaton Rapids
Willits, Clayton O......127 Upland, Charlotte

GENESEE COUNTY MEDICAL SOCIETY (62)

Abbott, R. Roderick......4101 Greenbrook Lane, Flint
Adams, Albert C......G 7194 E. Court St., Davison
Adams, Burnell H......609 S. Lynch St., Flint 3
Amato, Robt. M......1720 Ballenger Hwy., Flint
Anderson, Harley H......11820 N. Saginaw, Mt. Morris
Anderson, John L......2765 Flushing Rd., Flint 4
Anderson, Robt. E......420 S. Ballenger Hwy., Flint
Andrews, Nelson A. C......310 E. Main St., Flushing
Antell, Richard A......2733 Crestwood Dr., Flint
Anthony, Geo. E. R......1015 Detroit St., Flint 4
Baird, W. Claire......2765 Flushing Rd., Flint
Bald, Fredk. W......410 S. Ballenger, Flint 3
Barbour, David A......5369 Briarcrest, Flint
Barbour, Fleming A......2015 Lincoln Dr., Flint 3
Baske, Franklin W......923 Maxine St., Flint 3
Batdorf, Joseph T......11325 S. Saginaw, Grand Blanc
Bateman, Lawrence G......1928 Lewis St., Flint 6
Beck, Douglass R......1450 Country View Lane, Flint 7
Becker, Eugene B......2765 Flushing Rd., Flint 4
Bendush, Cecil L......806 W. 6th Ave., Flint
Benkert, Jack......6211 Lake Forest Dr., Grand Blanc
Benson, John C......402 W. 2nd St., Flint 3
Berman, Harry......3309 Fenton Rd., Flint 7
Berner, Gerald P......2765 Flushing Rd., Flint
Bernstein, Eli N......311 E. Court St., Flint
Berry, Robert E. L......715 Mott Foundation Bldg., Flint
Best, J. A......3803 Clio Rd., Flint 4
Beyer, George D......G 3337 W. Vienna, Clio
Biedlingmaier, G. J......12511 Via Catherina, Grand Blanc
Bishop, Don L......1024 Woodside Dr., Flint 5
Bogart, Leon M. (L)......503 National Bldg., Flint
Bolduc, Gregoire......325 E. First St., Flint
Boles, Wm. P. (L)......714 Beach St., Flint 3
Bosker, Donald......1620 N. Franklin, Flint 3
Bota, Robert A......1623 Montclair, Flint
Boyer, Peter R......100 Medical Arts Bldg., Flint
Bradley, Robt. M......1112 Mott Fdn. Bldg., Flint 2
Brain, Roy G. (L)......460 S. Saginaw St., Flint 3
Branch, Hira E......821 Mott Fdn. Bldg., Flint
Brasie, Donald R. (R)......310 Josephine St., Flint 4
Briggs, Guy D. (L)......224 E. Court St., Flint 3
Brown, Clarence A......2765 Flushing Dr., Flint 7
Bryant, Donald R......621 Mott Fdn. Bldg., Flint
Buchanan, Gerald S......211 S. Saginaw St., Holly
Buchanan, Wm. F......238 W. Caroline, Fenton
Burkett, Leslie V......121 E. 7th St., Flint 3
Canada, Donald R......218 E. Court St., Flint
Cassan, Stanley M......311 E. Court St., Flint
Chambers, Myrton S......3402 Westwood Pkwy., Flint 3
Chase, Wm. D......1318 N. Ballenger Hwy., Flint 4
Clark, Robt. L......1301 Flushing Rd., Flint 4
Collins, James I......G 1128 N. Dye Rd.,Flint
Colwell, Clifford W......328 S. Saginaw St., Flint 3
Conover, Geo. V......207 Genesee Bank Bldg., Flint 2
Conover, McCellan B......724 E. Street, Flint
Cook, Frank W......208 Genesee Bank Bldg., Flint

Cook, Henry (L)....208 Genesee Bank Bldg., Flint 2
Cook, John L....813 Mott Fdn. Bldg., Flint 7
Coriasso, Louis B....1515 W. Atherton Rd., Flint 4
Coyne, K. M....325 E. First St., Flint
Craig, William G....G. 3176 W. Court St., Flint
Cross, Robert L....6029 Marja, Flint
Curry, Geo. J. (L)....346 S. Saginaw St., Flint 3
Cutler, G. Campbell....420 S. Ballenger, Flint 4
Davis, Robt. C....G 3029 Flushing Rd., Flint 4
Dawson, Ralph E....721 W. Sixth Ave., Flint 4
Day, John Murray....721 W. Sixth Ave., Flint 4
Delzingro, Nicholas (L)....328 Main St., Davison
Dettman, Carlton K....12023 N. Seymour, Montrose
Dickstein, Bernard....605 National Bldg., Flint 3
Diggs, Roy D., Jr....5001 N. Saginaw St., Flint
Dismond, Samuel R....1402 S. Saginaw St., Flint
Dodds, Fredk. E. (L)....1336 Lewis St., Flint 6
Dodds, Max E....625 S. Grand Traverse, Flint
Dooley, James F....1609 Brookwood Dr., Flint 3
Drewyer, Glenn E....2001 Colchester, Flint 3
Dwyer, William F....625 S. Grand Traverse, Flint
Dykewicz, Richard A....2768 Flushing Rd., Flint 4
Eaton, Wayne L....2765 Flushing Rd., Flint
Eichhorn, Ernest M....2765 Flushing Rd., Flint 4
Eickhorst, Thos. N....2765 Flushing Rd., Flint 4
Elliott, Hardie B....503 S. Saginaw St., Flint 3
Engelman, Raymond M....103 Medical Arts Bldg., Flint 4
Ettinger, Ralph D....238 W. Caroline St., Fenton
Failing, John F., Jr....Hurley Hospital, Flint
Fan, Q. C....2002 E. Court St., Flint
Farah, Ben S....2765 Flushing Rd., Flint 4
Farhat, Maynard M....505 W. Court St., Flint
Fee, Manson G....108 E. Kearsley St., Flint 3
Ferris, James W....426 N. State St., Davidson
Finkelstein, Theo....1415 Broadway Blvd., Flint 6
Fitch, Robert E....1005 Leith, Flint 2
Forrer, Graydon R....2279 E. Grand Blanc Rd., Grand Blanc
Fuller, Harvey T. (R)....820 Genesee St., Mt. Morris
Gibbons, James J....101 Medical Arts Bldg., Flint
Goering, George R. (L)....2601 Norbert, Flint
Goetz, Margarete M. (A)....420 Genesee Bank Bldg., Flint
Goetz, Rudolph....1221 Church St., Flint
Golden, Evelyn....218 E. Court St., Flint
Golden, H. Maxwell....218 E. Court St., Flint 3
Gorne, Saul S....619 Clifford St., Flint 3
Griffin, Ernest P., Jr....1505 Arrow Lane, Flint 7
Grommons, Jack R....721 W. Sixth Ave., Flint
Grover, Harold F....601 S. Saginaw St., Flint 3
Guile, Gurdon S....1621 DuPont St., Flint 4
Gullekson, Edwin H....1917 Lynbrook Dr., Flint
Gumpper, C. R....4437 Morrish Rd., Swartz Creek
Gundry, Geo. L. (L)....Grand Blanc
Gutow, Isadore H....2765 Flushing Rd., Flint 4
Gutow, Julius J....726 Church St., Flint
Gutow, Richard F....203 Medical Arts Bldg., Flint
Gutowitz, Erwin....420 S. Ballenger Hwy., Flint
Guyon, Joseph F. (A)....302 W. Pierson, Flint
Guyon, Mary A....302 W. Pierson Rd., Flint 5
Hackley, Richard D....3942 Western Rd., Flint
Hague, Robt. F....210 E. Court St., Flint 3
Hallitt, John Wm....102 Medical Arts Bldg., Flint
Harper, Robt. H....713 Thomson St., Flint 3
Harris, Bernard J....1750 Lynbrook, Flint
Harris, Donald R....2429 Welch Blvd., Flint
Hauser, Fredk. V....1015 Mott Fndn. Bldg., Flint 2
Hawkins, James E....4618 Roberts St., Flint
Heine, John....302 Medical Arts Bldg., Flint
Heinemann, Herman J....G7316 Calkins Rd., Flint 7
Helcher, Phyllis O....G5303 Flushing Rd., Flushing
Hennessy, Charles R....517 Mott Fndn Bldg., Flint
Hiscock, Harold H....503 S. Saginaw St., Flint 3
Hockman, Thomas A....11125 Old Bridge Rd., Grand Blanc
Hodges, Frank V....Hurley Hospital, Flint 2
Hollis, John W....Fisher Body Div., Grand Blanc
Hooper, Virgil R....4230 Trumbull, Flint
House, Robert J....3133 Mackin Rd., Flint
Hubbard, Wm. B....1205 Maxine St., Flint 3
Hubbard, Wm. C....302 Paterson Bldg., Flint
Hufton, Wilfrid L....2765 Flushing Rd., Flint 4
Hunt, Richard J....6259 Lake Forest Dr., Grand Blanc
Hurd, Clayton E....205 Lincoln, Fenton
Irish, Lawrence R....346 Allendale Pl., Flint
Jacoby, John S....4300 S. Saginaw St., Flint
James, Robt. E....1515 W. Atherton, Flint
Johnson, A. H., Jr....3219 North St., Flint 5
Johnson, Frank D....625 S. Grand Traverse, Flint
Johnson, Raymond E....5173 W. Reid Rd., Swartz Creek
Judd, Alvin E....1620 N. Franklin, Flint 6
Karr, Paul H....3416 Lapeer Rd., Flint
Kaufman, Lewis D....4002 N. Saginaw St., Flint 5
Kelly, James E....2765 Flushing Rd., Flint
Kennett, Donald M....315 Bella Vista Dr., Grand Blanc
Kimbrough, C. B....1402 S. Saginaw St., Flint 3
Kirsten, Walter T....809 S. Ballenger, Flint
Kitto, Harold J....902 Stockdale, Flint
Kline, O. F....2765 Flushing Rd., Flint 4
Knapp, Wm. D....503 S. Saginaw St., Flint 3
Knoblich, Roman R....Hurley Hospital, Flint
Koop, Chester S....1372 N. Ballenger Hwy., Flint
Kretchmar, Arthur H....625 S. Grand Traverse, Flint
Kurtz, John J. (L)....601 S. Saginaw St., Flint 3
Laird, James I....12010 Kipp Rd., Goodrich
Laurel, Richard J....410 S. Ballenger Hwy., Flint
La Vielle, Carroll J....Hurley Hospital, Flint
Leach, J. Leonidas (L)....5014 N. Saginaw St., Flint
Le Mieux, Leslie L....701 W. Dayton St., Flint 4
Levine, Mark C....721 W. 6th Ave., Flint
Lewis, Billie....739 Mott Fdn. Bldg., Flint
Lewis, Thos. E....4071 Richfield Rd., Flint
Lewis, Vivian M....167 E. Hamilton Ave., Flint
Lightfoot, Arthur S....4500 Detroit St., Flint
Limbach, David R....900 Begole St., Flint 2
Lindman, Thomas C....2484 Nolen Dr., Flint
Livesay, Jackson E. (L)....503 S. Saginaw St., Flint 3
Lundeen, Richard M....3393 Clio, Flint
Lusk, John A....9233 W. Davison Rd., Davison
Lyttle, Sydney N....503 S. Saginaw St., Flint 3
MacGregor, Delbert M....701 W. Dayton St., Flint 4
MacKenzie, J. W., Jr....4437 Morrish Rd., Swartz Creek
Macksood, Albert J....3169 W. Pierson Rd., Flint
Macksood, Jos. A....3169 W. Pierson Rd., Flint 4
Macksood, William E....3169 W. Pierson Rd., Flint
MacPhail, Albert A....3302 Hawthorne Dr., Flint
Mangelsdorf, C. H....4122 Brownsell, Flint
Manwaring, John T....1654 Seminole St., Flint 3
Markunas, Paul J....4002 N. Saginaw St., Flint
Martin, James A....822 S. LeRoy, Fenton
Mathias, Berton J....1301 Flushing Rd., Flint 4
McAlindon, J. D....1601 Euclid, Flint
McClellan, Junius W....Buick Motor Division, Flint 7
McGarry, Roy A. (L)....601 S. Saginaw St., Flint 3
McGrae, John D., Jr....2433 Welch Blvd., Flint
McGregor, Allan R....G 3337 W. Vienna Rd., Clio
McLeod, Kenneth W. A....512 E. Grand Blanc Rd., Grand Blanc
McMurray, Richard J....2765 Flushing Rd., Flint
McTaggart, David....625 S. Grand Traverse, Flint
Mendrek, H. H....1639 Mott Fdn. Bldg., Flint 2
Michael, Sidney R....922 Welch Blvd., Flint 4
Michels, Robt. M. (A)....409 McKinley Rd., Flushing
Michelson, Richard B....2014 Robt T. Longway, Flint 3
Miller, Loren E....2645 Corunna Rd., Flint 3
Miltich, Anthony J....915 S. Grand Traverse, Flint 3
Moeller, Jan C....3802 Brentwood Dr., Flint
Moore, Glenn E....323 W. Second, Flint 3
Moore, Wesley P. (A)....18040 Sorrento, Detroit
Morin, Paul....1968 Miller Rd., Flint
Morrissey, Vaughn H....101 Stockdale St., Flint 4
Mosier, Edward C....115 Lake St., Otisville
Murphy, E. Grant....1825 Chelsea Circle, Flint 3
Newman, Harry S....816 E. Court St., Flint
Newton, Barabas (A)....McLaren Hosp., Flint
Nicholls, Wm. W....806 W. Sixth Ave., Flint 3
Nitz, Donald A....1515 W. Atherton Rd., Flint
Odle, Ira D. (L)....201 Welch Blvd., Flint 4
Oldt, Mary Ruth....602 S. Lynch St., Flint 3
Orr, John W. (L)....Orrs Pt. Lk. Fenton, Fenton
Osher, Seymour L....315 E. Court St., Flint 3
Parliament, Burt A....314 Ferndale Pl., Flint 3

Pfeifer, Archibald C. (L)........9798 Palmetto Club Dr., Miami, Fla.
Phelps, Lynn A........10122 Janaroy Ct., Goodrich
Phillips, A. F........X-Ray Dept. Hurley Hosp., Flint
Pickering, Woodrow H........1602 Ballenger Hwy., Flint 4
Pike, Wallace W........7514 Miller Rd., Swartz Creek
Platt, Alice Lee (A)........1430 Eldorado Dr., Flint
Portney, Jack E........725 Stevens St., Flint 3
Pougnet, W. D........6155 Maple Ridge, Flint
Pratz, Oliver C........1303 Detroit St., Flint 4
Preston, Otto J........300 N. Chevrolet Ave., Flint 2
Price, Jack R........410 S. Ballenger Hwy., Flint
Prior, Richard W........1266 S. Le Roy, Fenton
Purcell, F. L........Ternstedt Plant, Flint 5
Quin, John, Jr........2765 Flushing Rd., Flint 4
Rabiah, Fouad........1139 Mott Fdn. Bldg., Flint
Radcenko, Leonid........915 S. Grand Traverse, Flint
Ragan, Russell M........2768 Flushing Rd., Flint
Rao, D. S. (A)........McLaren Hosp., Flint
Rapport, Richard L........503 S. Saginaw, Flint 3
Rathburn, Robert J........1501 Flushing Rd., Flint
Rawling, John C........115 Med. Arts Bldg., Flint 4
Rawlings, J. Mott........1601 Neome Dr., Flint 3
Reid, John H........1301 Flushing Rd., Flint 4
Reye, George H........2279 E. Grand Blanc Rd., Grand Blanc
Rice, Alan K........2008 Robt. T. Longway, Flint
Rieth, Geo. F........1406 Davison St., Flint 6
Roberts, Floyd A. (L)........327 Sheffield, Apt. 281, Flint 3
Roth, F. Dale........606 Mott Fdn. Bldg., Flint
Rowe, John B........653 Saginaw St., Flint 3
Rulney, Max........2765 Flushing Rd., Flint 4
Rundles, Walter Z........500 Grand Traverse St., Flint 3
Sandberg, Russell G........2030 Pierce St., Flint 3
Sanocki, Fredk. E........1651 Detroit St., Flint 3
Scavarda, Chas. J........1106 Maxine, Flint
Schiff, Benton A........323 W. 2nd St., Flint 3
Schmidlin, Robt. W........3710 Davison Rd., Flint 6
Schreiber, E. Oskar........2765 Flushing Rd., Flint 4
Schroeder, Paul E........1673 N. Chevrolet, Flint
Schultz, J. Stanley........3327 Fleming Rd., Flint 4
Schwartz, John M........1300 N. Dort Hwy., Flint
Schwarz, Heinz H........1430 Eldorado, Flint
Scott, Robt D. (L)........1215 Detroit St., Flint 4
Seven, Phillip G........2301 Cummings, Flint
Seymour, Geo. D........G7237 N. Saginaw, Mt. Morris
Shantz, Leighton O........1497 Country View Lane, Flint 3
Sheeran, Danl. H. (A)........610 S Vernon Ave., Flint 3
Sherwood, Frederick........2765 Flushing Rd., Flint 4
Shields, John L........234 W. Caroline St., Fenton
Simoni, Lewis E........3210 S. Dort Hgwy, Flint 7
Sirna, Anthony R........11219 Stonybrook, Grand Blanc
Smalley, R. H........4437 Morrish Rd., Swartz Creek
Smith, Eugene C........606 Stevens, Flint
Smith, Harold O........3769 Sunset Dr., Flint 3
Smith, Maurice J........2801 N. Saginaw St., Flint 5
Smith, Sidney E........625 S. Grand Traverse, Flint
Sniderman, Benj. F........727 Beach St., Flint 3
Snyder, Chas. E........8129 Miller Rd., Swartz Creek
Solik, A. E........311 E. Court St., Flint
Sorkin, Morris L........718 Beach St., Flint 2
Sorkin, Saml. S........718 Beach St., Flint 2
Sparks, Harvey V........2765 Flushing Rd., Flint 4
Steffe, Ralph S........2765 Flushing Rd., Flint 4
Steinman, Floyd H........503 S. Saginaw St., Flint 2
Stevens, Philip K........1116 Mott Fdtn. Bldg., Flint
Stevenson, Wm. W. (L)........108 E. Kearsley St., Flint 3
Streat, Rudolph W. (L)........218 E. 8th St., Flint 3
Stroup, Clayton K........2002 E. Court St., Flint 3
Sullivan, M. R........1510 Forest Hill, Flint
Sutherland, James K........402 E. 3rd St., Flint 3
Sutton, Geo. D. (L)........303 W. Court St., Flint 3
Tang, Gene D........2765 Flushing Dr., Flint
Tauscher, John W........2016 R. T. Longway Blvd., Flint
Theuerle, Walter I........3101 N. Saginaw St., Flint 5
Thompson, Charles A........4211 Comstock St., Flint 4
Thompson, Jack W........2702 Flushing Rd., Flint 4
Thoms, Peter S........1279 W. Coldwater Rd., Flint
Thorburn, Grant (L)........No Address
Tofteland, Elmer H........2765 Flushing Rd., Flint 4
Tower, Rita B. (L)........2801 S. Dort Hwy., Flint 7
Turcke, Allen F........5717 Marja St., Flint 5
Turner, Merald G........G 3169 W. Pierson, Flint 2
Tuuri, Arthur L........Mott Children Clinic, Flint
Urich, Vernon........3169 W. Pierson Rd., Flint 2
Van Duyne, Fredk. W........2849 Miller Rd., Flint
Van Harn, Raymond S........1116 Ann Arbor St., Flint 5
Varney, Howard L........724 East St., Flint
Vaughan, Edgar J........319 S. Bridge St., Linden
Vergith, L. William........399 Coutant, Flushing
Wade, Franklin V........1121 Mott Fndt. Bldg., Flint
Walcott, Carver G........201 E. Carolina St., Fenton
Walker, James D........11325 S. Saginaw St., Grand Blanc
Walter, Daniel L........820 Davison Rd., Davison
Ward, Nell M. (L)........G4152 Carnation Ct., Flint 3
Weber, Robt. M........3710 Davison Rd., Flint 6
Wentworth, John E........420 S. Ballenger, Flint 4
Werness, Inga W. (L)........220 E. Fourth St., Flint
West, George A........6518 N. Saginaw St., Flint
Wheeler, J. D........2470 Nolen, Flint
White, Carl H........106 River St., Fenton
White, Frank T........5492 Lapeer Rd., Flint
Whites, Jack C........7343 Flushing Rd., Flushing
Willard, Robt. H........718 Beach St., Flint 3
Williams, T. Wendell........5003 N. Saginaw, Flint
Williams, Wm. S. (L)........5216 S. Genesee, Grand Blanc
Willis, Robert E........6606 N. Saginaw St., Flint
Wills, Thos. N. (R)........(Address Unknown)
Wolcott, Nan D........7506 Lapeer Rd., Davison
Wolf, Melvyn D........318 Medical Arts Bldg., Flint
Woodsides, K. T........7343 Flushing Rd., Flushing
Wright, Donald R........326 W. Court St., Flint
Wright, Geo. W., Jr........2765 Flushing Rd., Flint
Zeis, Myron G........718 Beach St., Flint 2
Zelko, Daniel M........4071 Richfield Rd., Flint

GOGEBIC COUNTY MEDICAL SOCIETY (66)

Albert, S. G........103 Suffolk St., Ironwood
Davidson, Donald L........200 S. Sophie St., Bessemer
Franck, John R., Jr........401 Sunday Lake, Wakefield
Gallo, Bela........Newport Clinic, Ironwood
Gertz, Michael A........109 E. Aurora St., Ironwood
Gorilla, Allen C........210 Suffolk St., Ironwood
Harrington, Rex R., Jr........104 E. Ridge St., Ironwood
Lieberthal, M. J. (L)........124 E. Gogebic, Ironwood
Lieberthal, Paul R........Box 632, Ironwood
Medford, Lester........306 Sunday Lake St., Wakefield
Murphy, Percy J........Seaman Bldg., Ironwood
Santini, Florian J........109 E. Aurora St., Ironwood

GRAND TRAVERSE-LEELANAU-BENZIE COUNTY MEDICAL SOCIETY (70)

Beall, John G........1105 E. Front St., Traverse City
Behan, Gerald W........Box C, Traverse City
Bolan, Ellis J........Suttons Bay
Brownson, Kneale M........116 Cass St., Traverse City
Bushong, Benjamin B........116 Cass St., Traverse City
Cajigas, Tomas R........J. D. Munson Hospital, Traverse City
Campbell, Thomas D........Box C, Traverse City
Cartwright, Wm. H........1105 E. Front St., Traverse City
Clark, Oswald V........Ramsdell Rd., Traverse City
Cline, Theodore N........999 6th, Traverse City
Cline, Warren W........999 6th, Traverse City
Coleman, John F........909 S. Maple, Traverse City
Dundon, Arthur F........Box C, Traverse City
Edmonds, W. T........Munson Hospital, Traverse City
Ellis, Claude I........Suttons Bay
Ferguson, John T........Box C, Traverse City
Fiebing, Jack A........P.O. Box 283, Traverse City
Fishbeck, Wm. A........1209 E. 8th St., Traverse City

Fox, Richard L..........207 Circle Dr., Traverse City
Goodrich, Dwight (R)........601 W. Front St., Traverse City
Haberlein, Chas. R..........1100 Sixth St., Traverse City
Hall, James W..........1100 Sixth St., Traverse City
Hamilton, Earl E..........530 S. Union St., Traverse City
Herkner, Mildred L..........119 Barlow St., Traverse City
Hubbell, Reader J..........228 S. Madison, Traverse City
Huene, Nevin..........110 E. Front St., Traverse City
Huston, R. R. (L)..........Elk Rapids
Johnston, James D..........1100 Sixth St., Traverse City
Kamp, Robt. L..........Beulah
Kaufman, James N..........427½ Main St., Frankfort
Kitti, Wm. W..........Kalkaska
Komesu, Seiichi..........Box C, Traverse City
Lemen, Charles E..........110 S. Madison, Traverse City
Lieding, Keith G..........7844 Peninsula Dr., Traverse City
Lossman, Robt. T.....J. Decker Munson Hosp., Traverse City
McClay, Adam C..........6330 Peninsula Dr., Traverse City
Michael, Stanley L..........335 Davis St., Traverse City
Milliken, John G..........224 Circle Dr., Traverse City
Nickels, Mervyn M..........Box C, Traverse City
Olsen, William R..........6 Buckingham Ct., Ann Arbor
Pelto, Maurice S..........Munson Hospital, Traverse City
Peterson, Wm. D..........876 E. Front St., Traverse City
Pike, Donald G..........1105 E. Front St., Traverse City
Ponczek, E. J..........Box C, State Hospital, Traverse City
Power, Frank H..........116 Cass St., Traverse City
Salon, Dayton D..........108 E. Front St., Traverse City
Schroeder, Dwight M..........Northport
Skendzel, L. P..........Munson Hospital, Traverse City
Sladek, Edward F. (L)..........123 E. Front St., Traverse City
Sommerness, M. Duane..........Box C, Traverse City
Sorum, F. T..........Box C, Traverse City
Spencer, John R..........1124 E. Front St., Traverse City
Steffey, Jos. C..........116 Cass St., Traverse City
Stokes, G. Edward..........1100 Sixth St., Traverse City
Swartz, Fred G. (L)..........612 Sixth St., Traverse City
Sweeney, Bernard J..........1100 Sixth St., Traverse City
Thacker, Fredk. R..........Front St., Frankfort
Thirlby, Richard L..........228 S. Madison, Traverse City
Wagener, Creighton A..........1100 Sixth St., Traverse City
Weih, Jack E..........1105 E. Front St., Traverse City
Weitz, Harry L..........Munson Hospital, Traverse City
Wilcox, Paul H..........333 Sixth St., Traverse City
Wiley, Philip K..........116 Cass St., Traverse City
Williams, Chas. R..........416 Sixth St., Traverse City
Willoughby, Gordon W..........408 Main St., Frankfort
Wolfgram, Lavern V..........1209 E. 8th, Traverse City
Wonacott, R. G..........107 Dexter, Elk Rapids
Wright, J. K., Jr..........1105 E. Front St., Traverse City
Wunsch, Richard E..........1122 E. Front St., Traverse City
Young, John Harley.......... .Box C, Traverse City
Young, Lloyd B.......... Route 2, Suttons Bay
Zielke, Irwin H..........106 S. Madison, Traverse City
Zimmerman, Jos. G..........102 W. Front St., Traverse City

GRATIOT-ISABELLA-CLARE COUNTY MEDICAL SOCIETY (74)

Aldrich, Alfred L..........Ithaca
Baker, Jerald F..........1127 E. High St., Mt. Pleasant
Barstow, Donald K..........215 W. Saginaw, St. Louis
Bauer, A. Robert, Jr..........412 E. Broadway, Mt. Pleasant
Becker, Myron G..........Edmore
Bedo, Andrew V..........802 Gordon, Mt. Pleasant
Bergin, Jos. H..........112 E. Superior, Alma
Binning, Griffith..........1328 N Drive, Mt. Pleasant
Brenner, E. J.......Central Mich. Comm. Hosp., Mt. Pleasant
Budge, Melvin J. (L)..........1035 Jefferson, Ithaca
Burt, Loren G..........510 Prospect St., Alma
Chamberlain, Ray W..........608 E. Chippewa, Mt. Pleasant
Chamichian, Souren L..........Canal Rd., Mt. Pleasant
Davis, Lionel L..........314 S. Brown St., Mt. Pleasant
Dunlop, Donald..........301 East Fourth St., Clare
Fishbaugh, Wm. F., Jr..........3765 Woodmere, Alma
Gervin, Irfan S..........231 East End St., Alma
Graham, Bernard J..........510 Prospect Ave., Alma
Haddad, T. E..........207 N. Franklin St., Mt. Pleasant
Hammerberg, Kuno..........622 McEwan, Clare
Harrigan, Wm. L..........412 E. Broadway, Mt. Pleasant
Hedges, Frank W..........215 W Saginaw, St. Louis
Hersee, Wm. E..........306 S. College, Mt. Pleasant
Hobbs, A. Deane (R)........Box 3233 Florence Vill., A Sta., Winter Haven, Fla.
Johnson, Frank D..........806 E. Bellows, Mt. Pleasant
Johnson, Philip R..........206 S. College Ave., Mt. Pleasant
Johnson, Robert B..........R. 1, Ithaca
Juhnke, LeRoy W..........314 S. Brown St., Mt. Pleasant
Klauer, James D..........Community Hosp., Mt. Pleasant
Leff, Wenzel A..........300 E. Grand, Mt. Pleasant
Linn, Michael R..........Gratiot Med. Arts Bldg., Alma
Lusis, Alexsandrs........St. Home & Tr. School, Mt. Pleasant
McArthur, Stewart C..........Box 32, Rosebush
Nagler, Donald F..........308 E. May St., Mt. Pleasant
Oldham, Earle S..........Breckenridge
Rank, Robert K.........Central Comm. Hospital, Mt. Pleasant
Ringer, Paul H., Jr..........314 S. Brown St., Mt. Pleasant
Roth, Wm. J..........303 W. Superior, Alma
Rottschaefer, John L..........3580 Northlawn Pk., Alma
Sanders, Jack F..........Mich. Masonic Home, Alma
Scott, Lincoln B., Jr..........417 S. College, Mt. Pleasant
Silvert, Pasche P..........Vestaburg
Smith, Dennis V. (L)..........1435 Cambridge, Ann Arbor
Soriano, D. A..........218 W. High St., Mt. Pleasant
Stack, John M..........310 Warwick Rd., Alma
Veldhuis, Andrew H..........801 Gordon Rd., Mt. Pleasant
Von Lackum, L. F.........535 Prospect Blvd., Waterloo, Iowa
Waggoner, Richard L..........120 N. Center St., St. Louis
Walkczyk, George..........No Address
Wallman, C. Harry..........901 State St., Alma
Wickert, Leo R..........1001 Watson Rd., Mt. Pleasant
Wilcox, Rex A..........525 State St., Alma
Wilson, Earl C..........Harrison
Wohlfeil, Dwayne L..........5851 Golfside Dr., Alma
Wolfe, Kenneth P. ....510 Prospect Ave., Alma
Wood, Cornelius B..........207 N. Franklin St., Mt. Pleasant
Wood, John M..........1300 S. Watson Rd., Mt. Pleasant

HILLSDALE COUNTY MEDICAL SOCIETY (78)

Bates, Morton P..........702-105 Cherry Lane, East Lansing
Davis, William B..........55 Barry, Hillsdale
Day, Luther W..........Grosvener Bank Bldg., Jonesville
Gates, Jon H..........379 S. Broad, Hillsdale
Henelt, Edmond..........32 S. Broad, Hillsdale
Hodge, Chas. L..........Reading
MacNeal, John A..........379 S. Broad, Hillsdale
Mattson, H. Frazyer..........32 S Broad St., Hillsdale
Peterson, Carl A..........59 Barry St., Hillsdale
Reigle, Frederick C..........Litchfield
Sawyer, Walter W..........61 N. Howell St., Hillsdale
Smith, Clark B..........379 S. Broad St., Hillsdale
Stein, Arthur J..........144 Budlong St., Hillsdale
Strom, Arthur W..........32 S. Broad St., Hillsdale
Tarr, John..........Camden
Trapp, Donald G..........32 S. Broad St., Hillsdale
Wiggins, Ira W..........Jonesville

HOUGHTON-BARAGA-KEWEENAW COUNTY MEDICAL SOCIETY (82)

Albright, John G..........232 Iroquois St., Laurium
Aldrich, Addison B..........325 Harris Ave., Hancock
Aldrich, Leonard C..........301 Quincy St., Hancock
Barrios, Honorato..........207 Huron St., Houghton
Hillmer, Raymond E. (L)..........Painsdale
Hosking, Fredk. S..........322 Calumet St., Lake Linden

Janis, Anton J....208 Quincy St., Hancock
Kolb, Fredk. E....128 Calumet Ave., Calumet
LaBine, Alfred (L) Masonic Bldg....Houghton
LaCore, Ivan A....Rice Memorial Clinic, Houghton
Lanczy, Tamas O....Baraga County Hospital, Lanse
Larson, Forrest W....322 Shelden, Houghton
Lepisto, Victor E....238 Quincy St., Hancock
Meier, Maurice D....1033 Mine St., Calumet
Parker, Thomas M....St. Joseph Hospital, Hancock
Repola, Kenneth L....401 Isle Royale St., Laurium
Roche, Andrew M....221 5th St., Calumet
Rowe, Kenneth E....107½ Calumet Ave., Calumet
Sandell, Samuel T....210 Center St., Hancock
Sloan, Paul S....609 Sheldon Ave., Houghton
Stroube, John A....522 W. Third, L'Anse
Williams, Marshall S....St. Josephs Hospital, Hancock
Winkler, Henry J....Box 461, L'Anse

HURON COUNTY MEDICAL SOCIETY (86)

Dixon, Ralph C....Box 77, Pigeon
Elliott, Chas. S....Pigeon
Gettel, Roy R....Bad Axe
Herrington, C. Clark....117 S. Port Crescent, Bad Axe
Herrington, Chas. I....Bad Axe
Herrington, K. B....317 Port Crescent, Bad Axe
Jones, David L....206 Heisterman St., Bad Axe
Mullaney, J. M., Jr....108 S. Port Crescent, Bad Axe
Oakes, Chas. W., Jr....Harbor Beach
Oakes, Robert W....7890 Sand Beach Rd., Harbor Beach
Scheurer, Clare A....Pigeon
Sidagis, Joseph....6 W. Main St., Sebewaing
Sorensen, Maurice G....P. O. Box, Elkton
Steinhardt, Edward E....Box 15, Elkton
Thompson, David H....117 S. Port Crescent, Bad Axe
Turner, Phillip R....230 S. First St., Harbor Beach
Wible, Chas. F., Jr....Sebewaing
Willits, Robert A....193 N. Main St., Elkton

INGHAM COUNTY MEDICAL SOCIETY (90)

Adams, Charles....2909 E. Grand River, Lansing
Agate, Geo. H....Mich. Dept. of Health, Lansing
Aiken, Donald J....Grandview & Grand Rv., Okemos
Alexander, Reuben G....301 Seymour Ave., Lansing 15
Allen, Robert E., Jr. (M)....1211 W. Main St., Lansing
Allis, Harry D....1322 E. Michigan, Lansing
Altland, J. K....Route 2, Box 178, Lansing
Altman, Harold (A)....Univ. of Missouri, Columbia, Mo.
Asselin, David C....1322 E. Michigan, Lansing
Badgley, Waldo O....624 N. Capitol Ave., Lansing
Baker, Thos. C....624 N. Capitol Ave., Lansing
Bassett, Robt. C....1322 E. Michigan Ave., Lansing 12
Bates, Richard....2909 E. Grand River, Lansing
Bauer, Theodore I....810 Mich. Nat. Tower, Lansing
Beaubien, Mark S. (A)....1006 Wildwood Dr., E. Lansing
Behen, Wm. C. (L)....535 S. Capitol Ave., Lansing
Behney, Charles A. (L)....Box 4256 San Jose Dr., Bisbee, Ariz.
Bellinger, Ernest G. (L)....Masonic Home, Alma
Berden, Eleanor A....2630 Libbie Drive, Lansing 17
Berens, Burdette M....Kalkaska
Berge, Richard E. (A)....1618 S. Genesee, Lansing 15
Bergeon, Milton C....1021 W. Dansville Rd., Mason
Bevez, Frank L....3209 S. Cambridge Rd., Lansing
Bingham, B. Wayne....1034 E Saginaw, Lansing 6
Black, Chas. E....112 W. Allegan, Lansing
Black, Gertrude C. K....529 W. Grand River, Williamston
Blair, Thomas C....1322 E. Michigan Ave., Lansing
Bleil, Eugene E....1322 E. Michigan Ave., Lansing
Boylan, Rowan C....15825 Samaritan Dr., San Jose, Calif.
Bradford, Carl W....832 Westlawn, East Lansing
Breakey, Robt. S. (R)....520 Westmorland, Lansing 15
Briggs, James....2132 N. Cedar St., Holt
Brown, Fredk. W., Jr....831 N. Washington Ave., Lansing
Brown, Joseph C....790 E. Columbia, Mason
Brubaker, Earl W....103 N. Washington Ave., Lansing 16
Bruegel, Oscar H. (L)....204 Birchwood Dr., Traverse City
Budden, M. Arthur....2909 E. Grand River, Lansing
Burge, Terry E....2132 N. Cedar, Holt
Byerrum, Mr. Richard U. (A)....602 Wildwood Dr., East Lansing
Cairns, Donald A....136 W. Ash St., Mason
Calomeni, Anthony D....1850 W. Mt. Hope, Lansing 15
Carlson, Ralph G....225 S. Waverly, Lansing 17
Carr, Earl I....300 W. Ottawa St., Lansing
Caruso, Joseph A....2909 E. Grand River, Lansing
Casey, Byron L....202 M.A.C., East Lansing
Chaskes, Marian I. G....210 E. Hillsdale St., Lansing
Cheney, Wm. D....Sparrow Hosp., X-ray, Lansing
Chi, Seong H. (A)....Ingham Medical Hosp., Lansing
Cipparone, Joseph R....St. Lawrence Hosp., Lansing
Clark, Gaius D....Oldsmobile Div., GMC, Lansing
Clark, Wm. E....131 E. Oak St., Mason
Clinton, George R....Rt. 2, Mason
Clore, Forrest C. (M)....No address
Combs, Robt. G....1023 E. Michigan Ave., Lansing 12
Comstock, Howard C....2909 E. Grand River, Lansing 12
Cope, Henry E. (R)....No address
Cordes, Jerome F....2909 E. Grand River, Lansing
Corneliuson, Goldie B....Mich. Dept. of Health, Lansing 15
Cowan, John A....825 Touraine, East Lansing
Crowe, Harold E....2909 E. Grand River Ave., Lansing
Cummings, Geo. D....Mich. Dept. of Health, Lansing 4
Dale, Edward C....Health Service MSU, East Lansing
Darling, Lewis H....115 W. Hillsdale St., Lansing 15
Dawe, C. D....1515 W. Mt. Hope Ave., Lansing
DeVries, Corydon F....320 Townsend St., Lansing 15
Dexter, M. J....229 E. Maple, Mason
Drolett, Alfred J. (L)....1018 Prudden Bldg., Lansing 16
Drolett, Donald J....1322 E. Michigan Ave., Lansing 16
Drolett, Lawrence A....3526 W. Saginaw St., Lansing 17
Dunkel, John F....Edw. W. Sparrow Hosp., Lansing
Dunn, Forest M....1322 E. Michigan Ave., Lansing
Ellis, Bertha W. (R)....Box 2327, Hollywood, Fla.
Ellis, C. Ward (L)....Box 2327, Hollywood, Fla.
Evans, Matthies....1250 Haslett Rd., East Lansing
Feeney, Kenneth J....1908 Mich Nat'l Tower, Lansing 15
Feurig, James S....321 Kensington, East Lansing
Flory, Clyde R....201 W. Hillsdale, Lansing
Folkers, Leonard M....234 Michigan Ave., East Lansing
Fortino, Silvio P....2909 E. Grand River, Lansing
French, Horace L....1322 E. Michigan Ave., Lansing
Fryer, Douglas H....Mich. Dept. of Health, Lansing 4
Garlinghouse, A. John, Jr....1322 E. Michigan Ave., Lansing
Gellar, Abraham....108 Division, E. Lansing
George, Harry C....335 Seymour St., Lansing 33
Ghannam, Rasem....2909 E. Grand River, Lansing
Ginnebaugh, L. A.(A)....77 Rose St., Battle Creek
Goldner, Roy E....1318 S. Washington Ave., Lansing 10
Govons, Sidney R....1322 E. Michigan Ave., Lansing
Grey, Anna B....915 Cajon, Redlands, Calif.
Hames, R. E....1322 E. Michigan Ave., Lansing
Hanna, Roger J....117 E. Maple, Mason
Harrington, Louis E....3526 W. Saginaw St., Lansing 17
Harris, Herbert W....609 N. Washington Ave., Lansing 15
Harrison, Wm. H....834 W. St. Joseph St., Lansing 15
Harrold, Jesse F....326 W. Ionia, Lansing 33
Hatton, R. L....4462 Greenwood St., Okemos
Hay, Kent R....1322 E. Michigan Ave., Lansing
Hayes, Robt. E....1322 E. Michigan Ave., Lansing 12
Hayford, Wm. D....1028 E. Saginaw St., Lansing
Heald, Gordon H....714 Abbott Road, East Lansing
Heckert, Frank B....1105 Bank of Lansing Bldg., Lansing 16
Heckert, Jos. K....1105 Bank of Lansing Bldg., Lansing 16
Heerdt, Mark E....810 W. Saginaw, Lansing
Henderson, Norman D....1017 E. Grand River, E. Lansing
Hermes, Edgar J....604 W. Willow St., Lansing
Heustis, Albert E....Mich. Dept. Health, Lansing
Himmelberger, R. J....3624 Colchester, Lansing 6
Hiscoe, D. Bonta....2909 E. Grand River, Lansing
Hoffer, W. E. (L)....331 Shepard St., Lansing

Hogg, Raymond E.................2909 E. Grand River, Lansing
Holland, Chas. F............................810 W. Saginaw, Lansing
Horvath, Francis............MSU Health Center, East Lansing
Howe, Gertrude E............................3500 N. Logan, Lansing
Howie, Charles....................1017 E. Grand River, E. Lansing
Hoyt, John C....................................2107 Aurelius Rd., Holt
Huggett, Clare C.................122 W. Gd. River Ave., Lansing
Hunt, Andrew D.....Coll. of Human Med., MSU, E. Lansing
Hurth, M. S..1717 Jerome St., Lansing
Imeson, Elizabeth W...................1809 Cahill Dr., E. Lansing
Isbister, J. L...................Dept. Health, DeWitt Rd., Lansing
Iung, Omero S.......................................411 Bartlett, Lansing
Jacob, S. Sprigg, III...................201 Ann St., East Lansing
Jarstfer, Bruce S. (A).................U.S.A. Tripler Gen. Hosp., Honolulu, Hawaii
Johnson, David B...................2909 E. Grand River, Lansing
Johnson, Henry T. (N).........................3501 W. VanBuren, Phoenix, Ariz.
Johnson, Kenneth H. (L)..1116 Mich. Nat'l Tower, Lansing
Johnson, Richard....................2909 E. Grand River, Lansing
Jones, Francis A., Jr. (R)......................815 Royal Palm Pl., Vero Beach, Fla.
Jones, Martin F.......................2909 E. Grand River, Lansing
June, Robt. C...............................209 N. Walnut, Lansing 33
Kahn, David...........................2909 E. Grand River, Lansing
Kalmbach, Roland E...................1322 E. Michigan, Lansing
Katlein, Stanley (A)................St. Lawrence Hosp., Lansing
Kellerman, Howard H...1322 E. Michigan Ave., Lansing 12
Kelly, William..Cass Bldg., Lansing
Kent, A. Edith Hall.............................. ......Box 1167, Lansing
Kent, Herbert K........................M.O. Box 1167, Lansing 13
Kenyon, Fanny H..........................624 LaSalle Blvd., Lansing
Kinzel, Raymond C.......................326 W. Ionia St., Lansing
Klunzinger, W. R.....................326 W. Ionia St., Lansing 33
Knisley, Wm. H...................731 Oakwood Dr., East Lansing
Kozak, Jerome S.............609 N. Washington Ave., Lansing
Kraft, Lester C...................................209 S. Main St., Leslie

Lambert, Harold J...............Mich. Dept. of Health, Lansing
Landick, Robt. E.............................810 W. Saginaw, Lansing
Lange, Philip F.......................1923 S. Cedar St., Lansing 10
Lanting, Helen E. P...............600 Lesher Place, Lansing 15
Larkey, Paul E.......................110 N. Rosemary St., Lansing
Larson, Homer I...........1322 E. Michigan Ave., Lansing 12
Lauzun, Virginia D.........1654 E. Grand River, East Lansing
LeDuc, Don M.....................1322 E. Michigan Ave., Lansing
Leshock, Jos. C.......................2909 E. Grand River, Lansing
Levett, Harry L.............2909 E. Grand River Ave., Lansing
Lewis, Clayton, Jr...................2909 E. Grand River, Lansing
Linnell, Paul C. (A)................1724 Covington, Ann Arbor
Long, Chas. O., Jr.................2909 E. Grand River, Lansing
Loree, Maurice C...............120 W. Hillsdale St., Lansing 15
Loughrin, T. D.....................................335 Seymour, Lansing
Love, James M...P.O. Box F, Okemos
Lovall, Kaare...............................209 N. Walnut St., Lansing
Lucas, Thos. A..........................1515 W Mt. Hope, Lansing
Ludlum, Lewis C...............1126 W. Saginaw St., Lansing 15
Malcolm, Henry E.................2909 E. Grand River, Lansing
Mannausa, L. R.............2909 E. Grand River Ave., Lansing
Marta, John B...................1720 Anderson Way, East Lansing
Martin, Wayne O.......................4765 Nakoma Dr., Okemos
Marzolf, M. Finette (N)......................3315 Wisconsin N.W., Washington 16, D. C.

Mavromatis, E.....................1322 E. Michigan Ave., Lansing
Mavromatis, F.....................1322 E. Michigan Ave., Lansing
Mav, Stephen G....................202 M.A.C. Ave., East Lansing
McCorvie, C. Ray........1410 Old Canton Lane, East Lansing
McCorvie, Donald R.....Williamston Med. Bldg., Williamston
McElmurry, Leland R...........209 N. Walnut St., Lansing 15
McFarlane, Donald R.....1322 E. Michigan Ave., Lansing 12
McGillicuddy, O. B. (L)....1816 Mich. Nat'l Tower, Lansing
McGillicuddy, R. J................300 W. Ottawa St., Lansing 15
McKenney, Marvin J...........1322 E. Michigan Ave., Lansing
Meade, Wm. H...........................1023 E. Michigan, Lansing
Meinke, Richard K.............1322 E. Michigan Ave., Lansing
Melick, Richard C.........................326 W. Ionia, Lansing 33
Mercer, Walter E. (R)............909 Glenhaven, East Lansing
Messenger, A. L.................1322 E. Michigan Ave., Lansing
Miller, J. Thomas..............................790 E. Columbia, Mason
Miller, Willard J.......................930 N. Washington, Lansing
Mirkil, V. Jerome...Box 2181, Lansing
Molina-Pung, Elba................1512 E. Michigan Ave., Lansing
Monfort, Robt. N. (R)..............300 Pacific Rd., Miami, Fla.
Moore, Charles R.................1322 E. Michigan Ave., Lansing
Moore, Donald B.........1322 E. Michigan Ave., Lansing 12
Morrow, Robt. J. (R)......................3117 Revere Pl., Lansing

Nakfoor, Eugene C.................2909 E. Grand River, Lansing
Neering, James C...........1322 E. Michigan Ave., Lansing 12
Neuman, John R.................3911 W. Michigan Ave., Lansing
Newitt, A. W............................221 W. Washtenaw, Lansing
Nicholas, Mildred V.............5596 Portage Lake Rd., Dexter
Niland, Paul T...............1322 E. Michigan Ave., Lansing 12
Ochsner, Paul J.......................Fisher Body Corp., Lansing 4
Packer, John H.......................2909 E. Grand River, Lansing
Palmer, R. E. (L).....................201 Petoskey Ave., Charlevoix
Parker, Earl E.....................................207 E. Bellevue, Leslie
Payne, Thomas C.........2909 E. Grand River Ave., Lansing
Peets, Ronald......................Gr. River & Grandview, Okemos
Philips, David P.....................1217 Loraine Ave., Lansing 10
Plant, John F.........................2909 E. Grand River, Lansing
Plesscher, Wm. H...............1322 E. Michigan Ave., Lansing
Pomeroy, Richard W...........1322 E. Michigan Ave., Lansing
Powell, Gerald D...............1515 W. Mt Hope Ave., Lansing
Prall, Harry J..........................214 W. Main St., Lansing 33
Randall, O. M. (R)................210 S. Clemens Ave., Lansing
Reid, Harold E.................359 University Dr., East Lansing
Reynolds, Edward E....................Rt. 2, Box B, Williamston
Rice, R. G..252 Hollister Bldg., Lansing
Richards, Frank D...............1322 E. Michigan Ave., Lansing
Richardson, Maurice L....................1215 E. Michigan Ave., Lansing 12
Robson, Edmund J.................215 N. Walnut St., Lansing 15
Rollstin, Robt. A..................1014 Townsend St., Lansing 21
Rozan, Josef S........................2909 E. Grand River, Lansing
Ruhmkorff, Ralph H.......MSU Health Center, East Lansing
Rutledge, Saml. H., Jr...1322 E. Michigan Ave., Lansing 12
Saenz, Hugo R...........................1515 W. Mt. Hope, Lansing
Saker, James H.........................201 W. Hillsdale St., Lansing
Sander, John F............................4780 Okemos Rd., Okemos
Sawvell, Austin R.....................810 W. Saginaw St., Lansing
Scallin, J. F.....................................810 W. Saginaw, Lansing
Schaffer, Carole S. (A)............846 Audubon Dr., E. Lansing
Scheidt, R. Rudolph..................1133 Seymour Ave., Lansing
Schmidt, Harry J...................2909 E. Grand River, Lansing
Schultz, Arthur E...........................4646 Ottawa Dr., Okemos
Seger, Fred L. (L)...............................1035 Cherry St. N.E., St. Petersburg 4, Fla.
Shapiro, Hyman D...................201 W. Hillsdale St., Lansing
Sharp, Mahlon S...............................521 N. Capitol, Lansing
Shaw, Milton..........................320 Townsend St., Lansing 15
Sheehan, F. Michael..................4361 Tacoma Blvd., Okemos
Sheets, Joseph L.......................521 N. Capitol Ave., Lansing
Sherman, Geo. A.....................112 W. Hillsdale, Lansing 15
Sichler, Harper G. (R)..........301 Seymour Ave., Lansing 15
Siegel, David..........................2909 E. Grand River, Lansing
Silverman, Irving E................2909 E. Grand River, Lansing
Sleight, Justin L.....................2909 E. Grand River, Lansing
Smith, Anthony V..........................116 W. Sycamore, Mason
Smookler, Bernard H.............2909 E. Grand River, Lansing
Snyder, LeMoyne.......................P.O. Box S, Paradise, Calif.
Snyder, Ruth C. E.......234 W. Michigan Ave., East Lansing
Spagnuolo, Alfred J......................1418 S. Logan St., Lansing
Spencer, J. Clyde..........................Sparrow Hospital, Lansing
Spencer, Perry C...................320 Townsend St., Lansing 15
Stanley, Arthur L..........................401 W. Greenlawn, Lansing
Stehman, Vernon A.......................Lewis Cass Bldg., Lansing
Steinem, David L.......Lansing Mental Health Ctr., Lansing
Steiner, Abraham A. (R)....................Route 3, Grand Ledge
Stephan, Winton E.............1322 E. Michigan Ave., Lansing
Stilwill, Geo. D.........................2909 E Grand River, Lansing
Stimson, Paul R..................119 E. Grand River, East Lansing
Stone, Benj. J.........................2909 E. Grand River, Lansing
Stow, Robt. M.........................2909 E. Grand River, Lansing
Strempek, Walter F...........726 Whitehills Dr., East Lansing
Stringer, C. J......................1322 E. Michigan Ave., Lansing
Sundell, Edwin C.................1322 E. Michigan Ave., Lansing
Swartz, Fredk. C.............................720 Seymour St., Lansing
Tamblyn, Fredk. W...............335 Seymour Ave., Lansing 33
Thaden, D. W........................208 M.A.C. Ave., East Lansing
Thimmig, Robt. F.........1322 E. Michigan Ave., Lansing 12
Tien, Hsin Chen..........124 W. Grand River Ave., E. Lansing
Toothaker, Kenneth W.....930 N. Washington Ave., Lansing
Trager, Fredk. C...........1322 E. Michigan Ave., Lansing 12

Trescott, Robt. F.................1322 E. Michigan Ave., Lansing
Trimby, Robt. H.................1322 E. Michigan Ave., Lansing
Troost, Franklin L..........................4378 W. Delhi Rd., Holt
Urban, Eva.................................540 Glenmoor, East Lansing
Vanderzalm, T. P...................1452 Cambridge Rd., Lansing
Velten, Hubert P.......................202 MAC Ave., East Lansing
Venier, Jos. H...............................544 Division, East Lansing
Wadley, Ralph.........................335 Seymour Ave., Lansing 33
Wainwright, James W.....................720 Seymour St., Lansing
Walker, Leo W.....................4225 Apple Tree Lane, Lansing
Warren, Leon H.........................3500 N Logan St., Lansing
Wasty, George (A)..................Henry Ford Hospital, Detroit
Wellman, John M.................1322 E. Michigan Ave., Lansing
West, Chas. Carl....................2909 E. Grand River, Lansing
Wiegenstein, John G.......................2107 Aurelius Road, Holt
Wilcox, K. R., Jr................Mich. Dept. of Health, Lansing
Wilensky, Thos..............................201 W. Hillsdale, Lansing
Willson, Howard S.............704 Mich. Nat'l Tower, Lansing 8
Worthington, Ralph.................810 W. Saginaw, Lansing 15
Wortley, Chas K...........1017 E. Grand River, East Lansing
Zick, Gerald A............1322 E. Michigan Ave., Lansing 12
Ziel, Hermann A., Jr...........Mich. Dept. of Health, Lansing

IONIA-MONTCALM COUNTY MEDICAL SOCIETY (94)

Anderson, D. Hess...........................207 Bridge St., Portland
Bennett, W. Bruce....................Lakeview Hospital, Lakeview
Bird, Wm. L.............................917 W Oak St., Greenville
Birzgalis, Alfreds A.......................Ionia State Hospital, Ionia
Buck, Jack H..517 Division, Ionia
Bunce, Leo W...Trufant
Campbell, Richard E...............................106 N. Depot, Ionia
Dunkin, Lloyd S.........................410 S. Clay St., Greenville
Foust, Jos. C. (A)................................Kisa Box 73, Tukuyu, Tanganyika, E. Africa
Geib, Oscar P. (L)..Gaylord
Halick, John...............................200 S. Franklin, Greenville
Hansen, Carl M...Stanton
Haskell, Robt. H. (L)..........................Zetlands Estate Twr., Nevis, Leeward Isl., B.W.I.
Hoffs, Marinus A.....................911 Fourth St., Lake Odessa
House, Glenn W., Jr.................1200 W Oak St., Greenville
Kazmers, Nikolas ....Lakeview
Kopchick, Jos...Muir
Kozachik, Martin J...........................123 Bridge St., Portland
Lilly, Isaac S. (L)...Stanton
London, John L...Lakeview
Marston, Leo L...Box 235, Lakeview
Merchun, Frank A.....11804 W. Carson City Rd., Greenville
Mitchell, Harold C...Box 3175 Nalcrest, E. Lake Wales, Fla.
Naglins, Jekabs...............................Ionia State Hospital, Ionia
Olsen, Bruce C..............................917 W Oak St., Greenville
O'Malley, R. J..230½ W. Main, Ionia
Rice, Robt. E...P.O. Box 271, Greenville
Robertson, Perry C. (L)..........................327 Center St., Ionia
Sanford, Louis E...219 Main St., Belding
Slagh, Milton E...Saranac
Smith, Robt. O..111 N. Kidd St., Ionia
Socha, Edmund S..217 E. Main, Ionia
Stevens, Charles E...............513 N. Lafayette St., Greenville
Tannheimer, John F.........................525 Lafayette St., Ionia
Younis, Ahmad......................505 S. Lafayette St., Greenville

JACKSON COUNTY MEDICAL SOCIETY (98)

Adams, Ellis W................................720 W. Franklin, Jackson
Ahronheim, J. H...............Foote Memorial Hospital, Jackson
Allen, Duane M...............Hanover Medical Center, Hanover
Appel, Saul..........................112 W. Michigan Ave., Jackson
Baker, Geo. M.......................................350 S. Union, Parma
Beckwith, Sidney A..................100 E. Main St., Stockbridge
Bentley, Jack P...................2532 Spring Arbor Rd., Jackson
Bentley, Mary E. N...........2532 Spring Arbor Rd., Jackson
Brashares, Zane A...Brooklyn
Bullen, G. R...418 Third St., Jackson
Buslepp, Robert C.....................901 Reynolds Bldg., Jackson
Clarke, Corwin S. (L)........Hacinda Carmel, Carmel, Calif.
Cooley, Chas. W.................................Mercy Hospital, Jackson
Cooley, Randall M. (L)..........141 E. Robinson St., Jackson
Corley, Cecil (L).......................204 Homecrest Rd., Jackson
Corley, Ennis H......................1401 Reynolds Bldg., Jackson
Corley, Robt. W........................204 Homecrest Rd., Jackson
Cox, Ferdinand (L)..............................1601 4th St., Jackson
Culver, Raymond E...................435 Wildwood Ave., Jackson
Daly, Byrne M...............................297 W. Michigan, Jackson
Davenport, Bruce.................................612 First St., Jackson
DeMay Cuthbert E. (L)......403 E. Michigan Ave., Jackson
DeMay, John D....................403 E. Michigan Ave., Jackson
Deming, Richard C.......................724 W. Franklin, Jackson
Dengler, Chas. R. (L)..............................504 3rd St., Jackson
Douglas, Edward W. (L)................................468 4th Avenue, New Kensington, Pa.
Filip, Hypolit K., Jr...............................P O. Box 84, Jackson
Finton, Robt. E...............................610 W. Michigan, Jackson
Greenbaum, Harry................1203 Greenwood Ave., Jackson
Growt, Bowers H. (L)...Addison
Habenicht, Hilda A.........................545 Lansing Ave., Jackson
Hackett, Thos. L...........................519 N. East Ave., Jackson
Hamilton, James G.......................610 N. West Ave., Jackson
Hanft, Cyril F.............................144 E. Main St., Springport
Hardie, Geo. C.............................724 W Michigan, Jackson
Hicks, Glenn C. (L).............1009 Wildwood Ave., Jackson
Holst, John B.............................606 City Bank Bldg., Jackson
Huldin, Donald H.................610 W. Michigan Ave., Jackson
Joerin, Wm. A.................................720 W. Franklin, Jackson
Karr, Jean P.........................502 W. Michigan Ave., Jackson
Keefer, Albert H...Concord
Kempton, Geo. B..........................511 S. West Ave., Jackson
Kiessling, A. J., Jr........................511 S. West Ave., Jackson
Kobs, Robt. J...............................720 W. Franklin St., Jackson
Kudner, Donald F.................766 W. Michigan Ave., Jackson
Lake, Edward C...............................720 W. Franklin, Jackson
Landron, Danl...........................4633 Page, Michigan Center
Lenz, Chas. R., Jr...405 1st St., Jackson
Lewis, Elmore F. (L)................1112 Carlton Blvd., Jackson
Linden, Victor E...............................2025 Fourth St., Jackson
Llinas, Jose J...1215 1st St., Jackson
Maas, Gerald I.............................1615 Carlton Blvd., Jackson
MacLean, Lloyd...............................710 S. Brown St., Jackson
McGarvey, Wm. E. (L)........161 W. Michigan Ave., Jackson
McLaughlin, John M...................710 S Brown St., Jackson
McLaughlin, Miar J. (L)............710 S Brown St., Jackson
McLauthlin, H. B.......................439 Wildwood Ave., Jackson
McQuillan, F. P..611 Center St., Jackson
Meads, Jason B.....................161 W. Michigan Ave., Jackson
Medlar, Robt. E.........................719 Seventeenth St., Jackson
Morelli, Lorenzo.......................401 W. Prospect St., Jackson
Muhich, Ralph A.................2532 Spring Arbor Rd., Jackson
Munro, Colin D. (L)..........................3849 Guest Rd., Jackson
Munro, Nathan D.................740 W. Michigan Ave., Jackson
Murphy, Bernard M...............1134 E. Ganson St., Jackson
Newton, Ray E. (L)............180 W. Michigan Ave., Jackson
Nichols, Harold.............................703 S. Webster St., Jackson
Niekamp, Harold................2532 Spring Arbor Rd., Jackson
Oleksy, Stanley P...........................744 W. Michigan, Jackson
Olsen, Lloyd L.....................610 W. Michigan Ave., Jackson
Oster, Harold L.....................1218 Greenwood Ave., Jackson
Otis, Grant L...............................525 Wildwood Ave., Jackson
Payne, Andrew K.............Foote Memorial Hospital, Jackson
Phillips, Geo. H..................Jackson Co. TB Sanat., Jackson
Pray, Frank F. (L)..........................310 Steward Ave., Jackson
Pray, Geo. R. (L)........................404 S. Jackson St., Jackson
Preston, Joseph A...............................Mercy Hospital, Jackson
Rice, John W...................................421 McNeal St., Jackson
Ries, Richard G...............................720 W. Franklin, Jackson
Riley, Philip A. (L).......................500 S. Jackson St., Jackson
Riley, Philip A., Jr.......................500 S. Jackson St., Jackson
Rodriquez, Leopoldo.........................720 W. Franklin, Jackson
Rua, Ignacio.......................................1810 W. High, Jackson
Rucker, Joseph...................................1012 Francis St., Jackson
Sargent, Leland E.............Foote Memorial Hospital, Jackson

Sautter, Wm. A.......Horton
Schmidt, Theophile E. (L)..180 W. Michigan Ave., Jackson
Schneider, R. H.......724 W. Franklin, Jackson
Scott, John A., Jr.......432 W. Michigan, Jackson
Schaeffer, Leland D.......1615 Carlton Blvd., Jackson
Sher, David B. (R).......3800 Kirkwood, Jackson
Sill, Henry W.......724 W. Michigan Ave., Jackson
Sirhal, Alfred M.......Brooklyn
Smith, Dean W.......500 W. Michigan Ave., Jackson
Southwick, W. A.......130 Maple Street, Springport
Stackable, Wm. R.......2532 Spring Arbor Rd., Jackson
Stewart, Lewis L., Jr.......1919 Kibby Rd., Jackson
Stolberg, Carl A.......724 W. Franklin, Jackson
Stone, Ethon L.......721 Seventeenth St., Jackson
Sugar, Saml.......180 W. Michigan Ave., Jackson
Tate, Cecil E.......1315 Francis St., Jackson
Taylor, Ross V.......517 Wildwood Ave., Jackson
Thalner, Leonard F.......609 W. Michigan Ave., Jackson
Thayer, Earl A. (L).......120 W. Michigan Ave., Jackson
Thompson, T. B.......434 Wildwood Ave., Jackson
Townsend, James W. (L).......108 Hauge Ave., Vandercook Lake, Jackson
Van Schoick, Frank.......419 W. High St., Jackson
Van Schoick, John D. (L).......Hanover
Van Schoick, R. M.......2120 Cascade Drive, Jackson
Van Wagnen, F. I., Jr.......434 Wildwood Ave., Jackson
Vivirski, Edward E.......603 S. Elm Ave., Jackson
Weddon, Edward R.......R.F.D. 2, Stockbridge
Wholihan, John W.......604 W. Michigan Ave., Jackson
Wickham, Woodward A.......2029 Fourth, Jackson
Wille, Warren S.......5325 Brown Lake Rd., Jackson

KALAMAZOO ACADEMY OF MEDICINE (102)

Aach, Hugo A.......3623 Duke St., Kalamazoo 37
Ajemian, Edward P.......252 E. Lovell St., Kalamazoo
Alexander, C. A.......118 W. North St., Kalamazoo
Andrews, Sherman E.......224 E. Cedar St., Kalamazoo 8
Andrews, Thomas E.......224 E. Cedar St., Kalamazoo
Angell, Howard H. (A).......301 Henrietta St., Kalamazoo
Anglin, Walter M.......7211 Lantollarrey Rd., Kalamazoo
Appel, Ben A.......252 E. Lovell St., Kalamazoo
Appell, Wm. P.......252 E. Lovell St., Kalamazoo 8
Appell, Lloyd E.......126 N. Kalamazoo Ave., Vicksburg
Armstrong, Robt. J.......103 N. Burdick St., Kalamazoo 1
Banner, Lawrence R.......Borgess Med. Center, Kalamazoo
Barrows, Winona M.......1500 Blakslee St., Kalamazoo
Barry, Manley L.......Plainwell Sanit., Plainwell
Bateman, William T.......914 S. Burdick, Kalamazoo
Bennett, Keith F.......252 E. Lovell St., Kalamazoo
Berglund, Thomas R.......6646 Portage Rd., Kalamazoo
Berglund, V. A.......6646 Portage Rd., Kalamazoo
Berry, Ivor, Jr.......516 Whites Rd., Kalamazoo
Betz, Eldean G.......1711 Merrill, Kalamazoo 6
Birch, Wm. G.......252 E. Lovell St., Kalamazoo 5
Bodmer, Harvey C.......403 W. Kalamazoo Ave., Kalamazoo
Breneman, James C.......25 Pearl St., Galesburg
Brooks, Bert W.......4340 Lakeside Dr., Kalamazoo
Brown, Irmel W. (L).......107 W. Michigan Ave., Kalamazoo
Brue, Peter P.......1009 Cambridge Dr., Kalamazoo
Burdick, Harry W.......1223 S. Park St., Kalamazoo
Burrell, Robt. B.......1711 Merrill St., Kalamazoo
Butler, Wm. J.......6552 Shepherd Hills, Tucson, Ariz.
Callander, C. Glen.......252 E. Lovell St., Kalamazoo
Carter, E. R.......1324 S. Park St., Kalamazoo
Cartland, Geo. F., Ph.D. (A).......1704 Dover Rd., Kalamazoo
Cashen, Russell M.......252 E. Lovell St., Kalamazoo
Chodos, Dale D. J. (A).......301 Henrietta St., Kalamazoo
Chrest, Clarence P.......458 W. South St., Kalamazoo
Christian, Daniel K.......252 E. Lovell St., Kalamazoo
Clement, F. L.......502 Bronson Med. Cen., Kalamazoo
Conrad, Maynard M.......252 E. Lovell St., Kalamazoo
Cooper, Paul F.......252 E. Lovell St., Kalamazoo
Cornish, F. L., III.......1631 Gull Rd., Kalamazoo
Cox, Franklin.......Borgess Hospital, Kalamazoo
Crawford, Kenneth L.......612 Douglas, Kalamazoo
Crawley, Kenneth R. (A).......301 Henrietta St., Kalamazoo
Creager, Ray O.......1218 Bronson Circle, Kalamazoo
Cretsinger, Francis C.......224 E. Cedar St., Kalamazoo
Croasdale, R. E.......252 E. Lovell St., Kalamazoo
Curran, Cyril J.......Borgess Hosp., Kalamazoo
Currier, Richard K.......6646 Portage Rd., Kalamazoo
Dahlstrom, Doris E.......723 S. Westnedge Ave., Kalamazoo
Damiano, Robert E.......301 Henrietta St., Kalamazoo
Dana, Robert L.......1631 Gull Road, Kalamazoo
Decker, Wm. A.......1207 Oakland, Kalamazoo
Delbert, Stewart G.......914 S. Burdick St., Kalamazoo
DeLong, Robt. E.......Borgess Med. Center, Kalamazoo
DePree, Harold E.......252 E. Lovell St., Kalamazoo
DeVries, John M.......516 Whites Rd., Kalamazoo
Dew, Robt. R.......1711 Merrill St., Kalamazoo
DeWitt, Norman L.......103 N. Burdick St., Kalamazoo
Dick, Leo A.......611 Howard St., Kalamazoo
Doezema, Edward R.......516 Whites Rd., Kalamazoo
Dowd, Bennard J.......1700 Gull Rd., Kalamazoo
Doyle, Fredk. M.......611 Howard St., Kalamazoo
Dugger, James A.......2901 S. Westnedge Ave., Kalamazoo
Endrei, Arisztid.......1312 Oakland Dr., Kalamazoo
Fath, August F.......1711 Merrill, Kalamazoo
Ferguson, Robt. K.......1324 S. Park, Kalamazoo
Finton, Max A.......252 E. Lovell St., Kalamazoo
Flunt, Roman.......Box A, Kalamazoo St. Hosp., Kalamazoo
Fopeano, John V.......1711 Merrill St., Kalamazoo
Fosmoe, Robert J.......458 W. South St., Kalamazoo
Fry, J. William.......212 Bronson Med. Center, Kalamazoo
Fuller, Paul M.......1700 Gull Rd., Kalamazoo
Gardner, Carl A.......1410 Amer. Nat'l Bank, Kalamazoo
Gerard, Earl S. (A).......3410 Runnymede Dr., Kalamazoo
Gerstner, Richard M.......212 Bronson Med. Ctr., Kalamazoo
Gibson, Richard E.......Schoolcraft
Gladstone, Wm. S.......458 W. South St., Kalamazoo
Glaser, Danl. F.......463 Academy St., Kalamazoo
Goodhue, Lolita G. (L).......2503 W. Main St., Kalamazoo
Gove, Robert S.......1631 Gull Rd., Kalamazoo
Graf, Michael.......1631 Gull Rd., Kalamazoo
Grekin, Robt. H.......136 E. Michigan Ave., Kalamazoo
Gremel, Norman.......458 W. South St., Kalamazoo
Haddock, D. A., Jr.......6646 Portage St., Kalamazoo
Hagans, James A.......301 Henrietta St., Kalamazoo
Hailman, Harold F.......P.O. Box 430, Yonkers, N. Y.
Hammer, John M.......100 Maple St., Parchment
Hanson, Curtis M.......252 E. Lovell St., Kalamazoo
Hare, J. Donald.......516 Whites Road, Kalamazoo
Harrell, Frank G.......1602 Gull Rd., Kalamazoo
Harrelson, Wm. D.......1324 S. Park, Kalamazoo
Hayner, Russell A.......4015 Portage, Kalamazoo
Heersma, H. Sidney.......1711 Merrill St., Kalamazoo
Heinle, Robt. W.......Med. Div., Upjohn Co., Kalamazoo
Hendrix, J. W.......515 Fineview, Kalamazoo
Hersey, E. Freeman.......1215 Oakland Drive, Kalamazoo
Hersey, Margaret S.......1215 Oakland Dr., Kalamazoo
Hildreth, Roscoe C.......458 W. South St., Kalamazoo
Hodgman, Albert B.......612 Douglas Ave., Kalamazoo
Hodgman, Richard W.......612 Douglas Ave., Kalamazoo
Hoekstra, George J.......100 Maple St., Parchment
Howard, Willard H.......1536 Gull Rd., Kalamazoo
Hubbard, Edwin M.......252 E. Lovell St., Kalamazoo
Hume, Robt. H.......1711 Merrill St., Kalamazoo
Hunt, Jack.......1631 Gull Rd., Kalamazoo
Huyser, Wm. C. (L).......427 S. Burdick St., Kalamazoo
Irwin, Wm. D.......103 N. Burdick St., Kalamazoo
Janke, Robert A.......1416 W. Milham Rd., Kalamazoo
Jennings, Robt. M.......Box A, Kalamazoo State Hosp., Kalamazoo
Johnson, Fenimore T. (A).......Med. Div. Upjohn Co., Kalamazoo
Kavanaugh, John.......1631 Gull Rd., Kalamazoo
Kavanaugh, T. E.......1631 Gull Rd., Kalamazoo
Kavanaugh, Wm. R.......612 Douglas Ave., Kalamazoo
Kercher, Ervin F.......2241 Sheffield, Kalamazoo
Kettunen, Robert C.......252 E. Lovell St., Kalamazoo
Kihm, John L.......1223 S. Park St., Kalamazoo
Kilgore, Robt. N.......252 E. Lovell St., Kalamazoo
Kincaid, Joseph E.......420 John St., Kalamazoo
Klerk, Wm. J.......914 S. Burdick St., Kalamazoo
Koestner, Paul A.......1303 Portage St., Kalamazoo

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Ortwig, Ralph W.....2342 Oakwood Dr. S.E., Grand Rapids
Outcalt, Herman A. (A)..........4460 S.W. Scholls Ferry, Portland 25, Ore.
Overbeek, Ernest L.....26 Sheldon Ave. S.E., Grand Rapids
Paalman, Russell J...26 Sheldon Ave. S.E., Grand Rapids 2
Palaszek, Theresa R..........833 Lake Dr. S.E., Grand Rapids
Pattullo, Marshall....515 Lakeside Dr. S.E., Grand Rapids 6
Payne, C. Allen..........1840 Wealthy St., Grand Rapids
Pedden, John R..........445 Cherry St. S.E., Grand Rapids 3
Peirce, John C..........515 Lakeside Drive S.E., Grand Rapids
Pilling, Warren C..........936 Orchard S.E., Grand Rapids 6
Piskin, M. S..........1077 Leonard St. N.E., Grand Rapids
Plekker, Johannes D.....833 Lake Dr. S.E., Grand Rapids 6
Pool, Lee R..........245 State St. S.E., Grand Rapids
Porter, Howard P..........833 Lake Drive S.E., Grand Rapids
Posthuma, Albert E.......153 Lafayette S.E., Grand Rapids 3
Postma, Edward Y..........245 State St. S.E., Grand Rapids 3

Postma, Howard F..................3860 Chicago Dr., Grandville
Potchen, E. James (A)........................721 Huntington Ave., Boston 15, Mass.
Pott, Abraham L.........1011 Fulton St. E., Grand Rapids 3
Prothro, Winston B.....1619 Walker St. N.W., Grand Rapids
Puite, Robert H.....515 Lakeside Dr. S.E., Grand Rapids 6
Pusczak, George B. (A).................1311 Northfield Dr. N.E., Grand Rapids
Raiman, Robert J.........50 College Ave. S.E., Grand Rapids
Ralph, L. Paul........2547 Oakwood Dr. S.E., Grand Rapids
Rasmussen, Richard A..........................Blodgett Med. Bldg., Grand Rapids 6
Reardon, D. F..............1168 Nixon N.W., Grand Rapids 4
Reus, Wm. F..............24 Burton St. S.E., Grand Rapids 7
Reus, Wm. F., Jr., 153 Lafayette Ave. S.E., Grand Rapids 3
Ribeilima, Jose........................832 Notre Dame, Grosse Pointe
Riekse, James M.....2740 Eastern Ave. S.E., Grand Rapids 7
Rienstra, John C. (A)...........1806 Evergreen, Grand Rapids
Ringenberg, J. C.......50 College Ave. S.E., Grand Rapids 3
Robb, Chas. S.............445 Cherry St. S.E., Grand Rapids 3
Robbert, John H..............................3011 Wilson, Grandville
Rodgers, Wm. L...............2865 Lake Dr. S.E., Grand Rapids
Roelofs, Charles W...3000 Monroe Ave. N.W., Grand Rapids
Rooks, Wendell H.........1339 Plainfield N.E., Grand Rapids
Roosenberg, William......................3000 Monroe Ave. N.W., Grand Rapids
Rosenzweig, Leonard..........................515 Lakeside Dr. S.E., Grand Rapids 6
Roth, Emil M...............604 Loraine Bldg., Grand Rapids 2
Rupke, John A.........324 Forest Hill Ave. S.E., Grand Rapids
Rupp, Theo. J...........50 College Ave. S.E., Grand Rapids 3
Ryan, John A..............153 Lafayette S.E., Grand Rapids 3
Ryskamp, James J., Jr. (A).................11423 Fair Oak Dr., Silver Springs, Md.
Santinga, John T. (A).......................207 Michigan, Petosky
Schaubel, Howard J.......124 Fulton St. E., Grand Rapids 2
Schek, Donald C.....2749 Clyde Park S.W., Grand Rapids 8
Schermerhorn, L. J. (R).......................2317 Vine Hill Rd., Santa Cruz, Calif.
Schlosser, Ralph J.........456 Cherry St. S.E., Grand Rapids 3
Schneider, Geo. R..............................1810 Wealthy St. S.E., Grand Rapids 6
Schnoor, Elmer W. (L)...................844 Iroquois Drive S.E., Grand Rapids 6
Schnute, Louise F.........146 Monroe N.W., Grand Rapids 2
Schwaderer, Thos. G. (A)..Box 291, APO, New York, N. Y.
Scott, Wm. B...........26 Sheldon Ave. S.E., Grand Rapids 2
Sculley, Raymond E.........12 Burton St. S.E., Grand Rapids
Seime, Reuben I...............201 Lafayette S.E., Grand Rapids
Sentkeresty, J. A.......515 Lakeside Drive S.E., Grand Rapids
Sevensma, Elisha S. (L)..1077 Leonard N.E., Grand Rapids
Sevensma, Eugene S. (A)........Wayne Co. Gen. Hosp., Eloise
Sharda, Martin..........2435 Eastern Ave. S.E., Grand Rapids
Sharp, Robert B............833 Lake Dr. S.E., Grand Rapids 6
Sidell, Richard H.....515 Lakeside Dr. S.E., Grand Rapids 6
Siebers, Bernard H.........1085 Leonard N.E., Grand Rapids
Siegel, Alan E.........1545 Diamond Ave. N.E., Grand Rapids
Sikkema, Donald E. (A)....................2909 Verle, Ann Arbor
Sluyter, John S.............2740 Eastern S.E., Grand Rapids 7
Smith, Dean B...............50 College Ave. S.E., Grand Rapids
Smith, John H.......1840 Wealthy St. S.E., Grand Rapids 6
Smith, Robt. B.........26 Sheldon Ave. S.E., Grand Rapids 2
Smith, R. Earle (L)..74 Ionia Ave. N.W., Grand Rapids 2
Snider, John D.......1827 Argentina Dr. S.E., Grand Rapids
Snyder, Clarence A.......445 Cherry St. S.E., Grand Rapids
Snyder, Clarence H...500 Cherry St. S.E., Grand Rapids 3
Southwick, C. H.....515 Lakeside Dr. S.E., Grand Rapids 6
Southwick, G. Howard (L).......................515 Lakeside S.E., Grand Rapids
Sprague, Wm. E.........1039 Fulton St. W., Grand Rapids 4
Starr, Charles R........26 Sheldon Ave. S.E., Grand Rapids 2
Steffensen, W. H.......1810 Wealthy St. S.E., Grand Rapids
Stonehouse, Garnet G (R).............408 Medical Arts Bldg., Grand Rapids 2
Stoneman, Fernley...........................3011 Wilson, Grandville
Stover, Virgil E...........860 Gladstone S.E., Grand Rapids 6
Strong, LeRoy E.....515 Lakeside Dr. S.E., Grand Rapids 6
Stuart, Gerhardus J. (L).....................1140 Keystone Ave., River Forest, Ill.
Sugg, Cullen E...............303 Fulton St. E., Grand Rapids 3
Sugiyama, Tetsuo......26 Sheldon Ave. S.E., Grand Rapids 2
Sun, Keh Ming......St. Mary's Hosp. Lab., Grand Rapids 3
Swan, Jerome W.....26 Sheldon Ave. S.E., Grand Rapids 2
Swanson, Alfred B..............................1810 Wealthy St. S.E., Grand Rapids 6
Swenson, Harold C.........124 Fulton St. E., Grand Rapids 2
Telego, A. J.........2505 Fletcher Dr. N.E., Grand Rapids 6
Ten Have, John....3515 Briggs Blvd. N.E., Grand Rapids 2
Ter Keurst, Donald H.......................2402 Eastern Ave. S.E., Grand Rapids 7
Tesseine, Arthur J.......1328 Madison S.E., Grand Rapids 7
Teusink, James H...Cedar Springs
Theodore, Paul G..........................1520 Plainfield Ave. N.E., Grand Rapids 5
Thompson, Athol B. (L)....................508 Fountain St. N.E., Grand Rapids
Thompson, Edward C.......................153 Lafayette Ave. S.E., Grand Rapids 3
Thompson, Frank D.....................4011 Reeds Lk. Blvd. S.E., Grand Rapids 6
Tiffany, Jos. C...........502 Medical Arts Bldg., Grand Rapids
Torgerson, Wm. R...Ramona Medical Center, Grand Rapids
Townsend, Jack H., 515 Lakeside Dr. S.E., Grand Rapids 6
Troske, Robt. L.............250 Fuller St. S.E., Grand Rapids 6
Truog, Clarence P.........110 Fulton St. E., Grand Rapids 2
Turcotte, V. J., Jr...515 Lakeside Dr. S.E., Grand Rapids 6
Vaandrager, Vernon D. (A)................1030 Knapp St. N.E., Grand Rapids
Valdmanis, Ferdinands....2120 Lake Dr. S.E., Grand Rapids
Van Bree, Raymond S...812 Rosalie N.W., Grand Rapids 4
Van Dam, Forrest R...1810 Wealthy St. S.E., Grand Rapids
Vanden Berg, A. R.......833 Lake Dr. S.E., Grand Rapids 6
Vanden Berg, Henry J. (L)...........2933 Bonnell Road S.E., Grand Rapids
Vanden Berg, Robt. J. (A).............2151 Hubbard, Apt. 24, Ann Arbor
Vanden Berg, Wm. O..........................50 College Ave. S.E., Grand Rapids 3
Vander Kolk, K. J..........................2740 Eastern Ave. S.E., Grand Rapids 7
Vander Meer, Raymond......................26 Sheldon Ave. S.E., Grand Rapids 2
Vandermolen, John......124 Fulton St. E., Grand Rapids 2
Vander Ploeg, R. A.....26 Sheldon Ave. S.E., Grand Rapids
Vander Ploeg, Wm. H., 833 Lake Dr. S.E., Grand Rapids 6
Van Der Veer, Corwin G........................245 State St. S.E., Grand Rapids 3
Van Dommelen, G. M..........................456 Cherry St. S.E., Grand Rapids 3
Van Duine, Henry J.....153 Lafayette S.E., Grand Rapids 3
Van Dyke, Harold E...1108 Leonard St. N.E., Grand Rapids
Van Etten, Donald D. (A)..........Box 13, Orange City, Iowa
Van Goor, Kornelius...........................26 Sheldon Ave. S.E., Grand Rapids 2
Van Otteren, G. F. (A)....................2122 Gordon St. N.W., Grand Rapids
Van Portfliet, Paul........245 State St. S.E., Grand Rapids 3
Vansolkema, Andrew A.....953 E. Fulton St., Grand Rapids
Van T'Hof, Albert......50 College Ave. S.E., Grand Rapids 3
Van Vliet, Peter D. (A)..................1416 Berkman Ct. S.W., Rochester, Minn.
Van Woerkom, Danl..........................933 Leonard St. N.W., Grand Rapids 4
Van Zanten Kuiper, K...................2208 Madison Ave. S. E., Grand Rapids
Van Zwalenburg, B. R.....................2116 Coronado Dr. S.E., Grand Rapids
Vasu, C. Mark..............833 Lake Drive S.E., Grand Rapids
Veldman, Harold E.........26 Sheldon Ave., Grand Rapids 2
Veltman, Jay H........................3946 G 30th St., Grandville
Venema, Jay R., 540 Overbrook Lane S.E., Grand Rapids 7
Ver Lee, Jimmie J. (A)............Galmi Hospital, Galmi Via, Madaoua, Nigeria Republic, West Africa
Ver Meulen, John (L)..........2400 Wyoming, Grand Rapids
Ver Meulen, Peter (A)....105 Baynton N.E., Grand Rapids
Verwys, A. L. Hubert....815 Alger St. S.E., Grand Rapids 7
Vining, Keats K., Jr...515 Lakeside Dr. S.E., Grand Rapids
Vis, William R. (L)..26 Sheldon Ave. S.E., Grand Rapids 2
Visscher, H. C.........515 Lakeside Dr. S.E., Grand Rapids 6
Visscher, Robert D.....515 Lakeside Dr. S.E., Grand Rapids
Visser, Earl R.................124 Fulton St. E., Grand Rapids 2
Vogel, Anton..........1204 Madison Ave. S.E., Grand Rapids
Volkel, James S...............833 Lake Drive S.E., Grand Rapids
Voss, John A.........2060 Alpine Ave. N.W., Grand Rapids 4
Vyn, Jay D.................7119 Driftwood S.E., Grand Rapids 6

Wahby, Elmer F.......300 Bostwick Ave. N.E., Grand Rapids
Walma, Daniel..............25 Sheldon Ave. S.E., Grand Rapids
Wassink, Roger N.........26 Sheldon Ave. S.E., Grand Rapids
Waterman, Donald F...515 Lakeside Dr. S.E., Grand Rapids
Webb, Clarence F.........833 Lake Dr. S.E., Grand Rapids 6
Webber, Jerome E.....50 College Ave. S.E., Grand Rapids 3
Weeber, Thomas A................3011 Wilson S.W., Grandville
Wehrenberg, R. A. (A).................2602 Frederick Dr. S.E., Grand Rapids
Weller, Keith E...........1200 Lake Dr. S.E., Grand Rapids 6
Wells, S. Merrill Jr. (L)...........2716 Bonnell Dr. S.E., Grand Rapids 6
Wendt, Vernon E.........1840 Wealthy St. S.E., Grand Rapids
Wenger, John N. (L)........112 Eastmanville St., Coopersville
Westendorp, Floyd..6850 Division Ave. S., Grand Rapids 8
Westerhoff, Robert J.....................2740 Eastern Ave. S.E., Grand Rapids
Whinery, Jos. F.....50 College Ave. S.E., Grand Rapids 3
Whitehouse, John D.................1201 Colorado Ave. S.E., Grand Rapids 6
Whittenberger, R. N.....245 State St. S.E., Grand Rapids 3
Wiese, John L.........50 College Ave. S.E., Grand Rapids 3
Wilderom, Morris........1619 Walker St. N.W., Grand Rapids
Wilkes, John B.....1328 Madison Ave. S.E., Grand Rapids 7
Wilkinson, C. A.........2030 Leonard St. N.W., Grand Rapids
Williams, John R...............833 Lake Dr. S.E., Grand Rapids
Wilson, John R.........1033 Fulton St. W., Grand Rapids
Wilson, Robert J.........1011 Fulton St. E., Grand Rapids
Wilson, Wm. E. (R)...................37 Prospect Ave. N.E., Grand Rapids
Winfield, Emery D. (L)........457 Burton S.E., Grand Rapids
Winter, Garrett E........................1967 Godfrey Ave. S.W., Grand Rapids 9
Wright, Thos. B..............................2614 Plainfield Ave. N.E., Grand Rapids 8
Wurz, John F.........201 Norwood Ave. S.E. Grand Rapids 6
Wyngaarden, Martin K............................245 State St. S.E., Grand Rapids 3
Yared, Jerome A.....651 Cherry St. S.E., Grand Rapids 6
Yost, William G. Jr............................50 College Ave. S.E., Grand Rapids 3
Young, Donald G.......100 Michigan St. N.E., Grand Rapids
Zadvinskis, Z.................833 Lake Dr. S.E., Grand Rapids
Zimmerman, Wm. G.....26 Sheldon Ave. S.E., Grand Rapids
Zwemer, Rodger J............................1810 Wealthy St. S.E., Grand Rapids

LAPEER COUNTY MEDICAL SOCIETY (110)

Abruzzo, Anthony M...................Lapeer State Home, Lapeer
Baybura, Orhan (A)....................Lapeer State Home, Lapeer
Berker, Isak O.....................................South Street, Davidson
Bishop, G. Clare...Almont
Boruch, Leon R.........Drawer A, Lapeer State Home, Lapeer
Conaway, Chas. E.....................1257 N. Main St., Lapeer
Dorland, Clarke............................221 Lincoln St., Lapeer
Doty, James R..315 Clay St., Lapeer
Ergin, Nevit (A).........................Lapeer State Home, Lapeer
Greavu, Cornell Jr.......................................North Branch
Haney, M. Bennet.......................409 E. St. Clair St., Almont
Heitsch, Wm. C.......................................307 Clay St., Lapeer
House, Clifford...............................1750 Grey Rd., Lapeer
Kiehler, E. G., II......................1444 W. Genesee St., Lapeer
Kim, S. J.....................1401 S. Washington Ave., Royal Oak
Kocur, Lubomira..........Drawer A, Lapeer St. Home, Lapeer
Lebedovych, Emil.........Drawer A, Lapeer St. Home, Lapeer
Lebedovych, Ksenia....Drawer A, Lapeer St. Home, Lapeer
Leith, Dorothy L........................240 Main St., Imlay City
Lynk, Stanley M...........................4589 Lippincott, Lapeer
McBride, John R....................431 Washington St., Lapeer
Pappalardo, Carlos...............................1651 Detroit St., Flint
Rubio, Epimaco.......................1555 Cherboneau Pl., Detroit
Smith, Ellen...................400 White Rd. R. 1, Columbiaville
Smith, Glenn L..................6552 Imlay City Rd., Imlay City
Zemmer, H. R...N. Main St., Lapeer
Zolliker, Carl R. (R)...................3646 Slattery Rd., Lum

LENAWEE COUNTY MEDICAL SOCIETY (114)

Abraham, A. O..Hudson
Allen, Russell A.........................415 W. Maumee St., Adrian
Armovit, Hermino.........................236 S. Fourth St., Onsted
Balace, F. W....................................128 E. Butler St., Adrian
Benz, Carl A.................................308 N. Broad St., Adrian
Berghuis, John...........................693 Stockford Dr., Adrian
Blanchard, Lowell E...Hudson
Blanden, Merwin R..Tecumseh
Boyd, James W......................4510 Southgate Lane, Adrian
Campbell, Joseph........1114 Knollwood Pl., Martinsville, Va.
Claxton, Wilbert T...Britton
Coak, Richard D.............602 E. Pottawatamie St., Tecumseh
Cook, Carlton L.................603 E. Pottawatamie, Tecumseh
Diccion, R. A...Addison
Dickman, Harry M................................104 Oak St., Hudson
Dustin, Richard E.....................103 W. Brown St., Tecumseh
Eddy, Howard R. C......................................Mill Rd., Adrian
Feeney, James L..Mill St., Adrian
Fitzsimmons, Francis J.................424 Oregon Rd. W., Adrian
Galliani, M................................4410 Evergreen Dr., Adrian
Gamble, Kenneth..R. 3, Hudson
Gascoigne, Richard H...................693 Stockford Dr., Adrian
Gilkey, William C......................693 Stockford Dr., Adrian
Gilmartin, Richard...Mill St., Adrian
Greiner, Robert A.........................Professional Bldg., Adrian
Hamilton, John..Mill St., Adrian
Hammel, Richard T..Tecumseh
Hammersley, Gordon....................1361 Oregon Rd., Adrian
Harrison, Robt. E.............................418 W. Adrian, Blissfield
Heffron, Chas. H..........................231 N. Main St., Adrian
Heffron, C. Harold (A)................231 N. Main St., Adrian
Heffron, Howard H.....................231 N. Main Street, Adrian
Helzerman, Ralph F................112 S. Ottawa St., Tecumseh
Hewes, Wm. H..Mill Rd., Adrian
Hunt, Philip..Mill St., Adrian
Locke, Francis A.................................755 High St., Adrian
Marsh, Roland G. B. (L)....1938 Spruce St., Boulder, Colo.
Miller, P. Lynford........................310 E. Maumee St., Adrian
Ocamb, Harold D................600 E. Pottawatamie, Tecumseh
O'Connor, Archie R......................109 Tecumseh Rd., Clinton
Parker, Donald A............................Bixby Hospital, Adrian
Patmos, Bernard........................127 E. Maumee St., Adrian
Phelan, Alvin J.......................................10 Cairns, Tecumseh
Raabe, Elmer C...Morenci
Richey, Bert R..................765 Manitou Rd., Manitou Beach
Sarapo, Donato F...Mill St., Adrian
Shannon, Gordon..Blissfield
Skufis, Eleanor P............................201 Orchard Rd., Adrian
Skufis, Xenophon...............................123 E. Chestnut, Adrian
Stewart, Landis C.................................750 High St., Adrian
Van Dusen, Chad A. (L).............................RFD 5, Blissfield
Wentz, Patricia...760 Riverside, Adrian
Whitehouse, Keith H...Morenci
Wilson, Geo. C..Box 224, Clinton
Wolf, Marvin B............................689 Stockford Dr., Adrian
Wynn, Geo. H...............................1115 W. Maumee, Adrian

LIVINGSTON COUNTY MEDICAL SOCIETY (118)

Barton, Thos. A..............................116 N. Michigan, Howell
Chelski, Morris.........................116 W. Grand River, Brighton
Clarke, Niles A..............................624 Spencer Rd., Brighton
Damstra, Donald L.............12893 E. Grand River, Brighton
Duffy, Ray M. (L)........................P.O. Box 106, Pinckney
Harebottle, Norman...Fowlerville
Hauer, R. Fred..Fowlerville

Hendren, Jesse J. (R)	Fowlerville
Higby, Thomas F.	Fowlerville
Hill, Harold C.	116 N. Michigan Ave., Howell
Hoffman, Stanley L.	1200 Byron Rd., Howell
May, Louis E.	City Route 4, Howell
Perry, Florence J. C.	17640 San Rose Ave., Lathrup Village
Phillips, R. W.	Hamburg
Polack, Robt. T.	1223 Thruber Dr., Howell
Schenden, A. J. (R)	6335 W. M-36, Pinckney
Sheng, Luke H. C.	111 W. Grand River, Brighton
Smith, Russell F.	9569 Main St., Whitmore Lake
Stuber, Roscoe V.	1200 Byron Rd., Howell
Walker, Enos G.	4485 Cordley Lake, Lakeland
Wang, Stella K. C.	111 Grand River, Brighton
Woodworth, Edwin S.	1200 Byron Rd., Howell

LUCE COUNTY MEDICAL SOCIETY (122)

Cameron, Richard R.	701 W. Olivea, Owosso
Gibson, Robt. E. L. Jr.	207 W. John St., Newberry
Gorham, Arwin	U. S. 2, Iron Mountain
Grennan, Lawrence E.	Newberry
Hicks, R. P.	210 W. John St., Newberry
Keizer, B. G.	Newberry State Hosp., Newberry
LaSalle, Michael	Newberry State Hosp., Newberry
Purmort, Wm. R., Jr.	Newberry State Hosp., Newberry
Surrell, Matthew A.	210 W. John St., Newberry
Thompson, Thos. W.	8160 Huron St., Dexter

MACOMB COUNTY MEDICAL SOCIETY (126)

Adler, Morton W.	19188 Appoline St., Detroit 35
Alexander, James H.	25815 Harper, St. Clair Shores
Alvarez, Mercedes	11686 Eleven Mile Rd., Warren
Ambrose, Robt. H.	18801 E. Ten Mile Rd., Roseville
Arellano, Miguel A.	21500 Mound Rd., Warren
Audretsch, F. E.	36275 Alfred, New Baltimore
Barker, John G.	8050 Warren Blvd., Center Line
Beecher, Alvin J.	21501 Kelly, East Detroit
Bigley, Bernard	35992 Gratiot, Mt. Clemens
Biluk, Frank J.	GM Tech. Center, Warren
Bishai, Yousef B.	11477 E. 12 Mile Rd., Warren
Bond, Franklyn F.	4861 E. Nine Mile Rd., Warren
Bower, Allen B. (L)	Armada
Brown, Leland C.	21536 Parkway, St. Clair Shores
Bryce, James W.	25219 Van Dyke Ave., Center Line
Buckley, Danl. J.	160 S. Walnut St., Mt. Clemens
Carruthers, W. B.	303 Monitor Leader Bldg., Mt. Clemens
Chabator, George	294 Benjamin St., Romeo
Charbeneau, Harold P.	229 S. Gratiot, Mt. Clemens
Charbonier, Luis M.	11868 E. Eleven Mile Rd., Warren
Clay, Joel W.	263 S. Gratiot Ave., Mt. Clemens
Cohen, Alan	12500 12 Mile Rd., Warren
Colah, Sorab A.	708 Monitor Leader Bldg., Mt. Clemens
Collon, David, D.D.S. (A)	Romeo
Corbett, John	225 S. Gratiot, Mt. Clemens
Cosio, Jose	St. Joseph Hospital, Mt. Clemens
Courtney, Rufus S.	St. Joseph Hospital, Mt. Clemens
Croman, Jos. M., Jr. (R)	131 Market St., Mt. Clemens
Curatolo, Victor	67 Cass Ave., Mt. Clemens
Darian, H. B.	11528 E. 12 Mile Rd., Warren
Deal, Harold R.	23700 Van Dyke, Warren
Deocampo, E.	28430 Hoover Rd., Warren
Deocampo, Nestor D.	No address
Depaulis, Dario C.	22770 Kelly, East Detroit
Dragulescu, Paul	27440 Hoover Rd., Warren
Dudzinski, Edmund J.	424 Washington St., New Baltimore
Ebner, Charles M.	26401 Harper, St. Clair Shores
Ekelman, Seymour B.	14 Belleview, Mt. Clemens
Ellias, Elmer P.	23700 Van Dyke, Warren
Engels, John A.	69311 N. Main, Richmond
Erkfitz, Arthur W.	26401 Harper Ave., St. Clair Shores
Finn, James Wm.	46056 Cass, Utica
French, Lawrence W.	25815 Harper, St. Clair Shores
Fulgenzi, Andrew A.	17301 E. Eight Mile Rd., East Detroit
Gerbasi, Francis	81 Lochmoor Blvd., Grosse Pte. Shs.
Gesser, Charles	17800 E. 8 Mile Rd., Harper Woods
Goldin, Morris I.	6902 Chicago Rd., Warren
Goldman, Bernard J.	243 S. Gratiot Ave., Mt. Clemens
Gonzalez, Salvador	1756 Allard, Grosse Pointe Woods
Hahne, Otto H.	8425 E. 12 Mile Rd., Warren
Hartmann, Waldemar B.	1416 S. Gratiot, Mt. Clemens
Hiller, Herbert M.	13500 E. 12 Mile Rd., Warren
Hirzel, Leon S.	33080 Garfield, Fraser
Horvath, Julius	18847 Rosetta, East Detroit
Hoski, A. Joseph	8425 E. Twelve Mile Road, Warren
Hranchook, Michael	30001 Van Dyke, Warren
Hull, Frank J.	38224 Jonathan, Mt. Clemens
Iglesias, Ernesto R.	608 Monitor Leader Bldg., Mt. Clemens
Isaacs, Eli M.	24579 Rensselaer Blvd., Oak Park 37
Isbey, Edward K.	25020 Van Dyke, Center Line
Ivkovich, Peter (A)	12501 E. 23 Mile Rd., Utica
Jacobs, Manuel	23700 Van Dyke Ave., Warren
Jewell, James H.	Roseville Theatre Bldg., Roseville
Kane, John P.	67 Cass Ave., Mt. Clemens
Kane, Peter V.	67 Cass Ave., Mt. Clemens
Kane, Wm. J. (L)	171 North Ave., Mt. Clemens
Keitges, P. W.	Western Reserve Univ., Cleveland, Ohio
Kingsley, Joyce W. Jr.	18801 Ten Mile Rd., Roseville
Kirker, J. G.	1328 Michigan Ave., Marysville
Kirtland, Wm. B., Jr.	18801 E. Ten Mile Rd., Roseville
Klein, Alfred A.	23700 Van Dyke, Warren
Knoblauch, K. H.	8425 Twelve Mile Rd. E., Warren
Kommel, Richard M.	26510 Dundee, Huntington Woods
Kripke, Morton J.	52080 Van Dyke, Utica
Kroon, Joseph D.	37984 Bonkay, Mt. Clemens
Kurtz, Hyman (A)	21414 Hillside, Mt. Clemens
Kypros, George P.	26401 Harper St., St. Clair Shores
Laporte, Lawrence A.	356 N. Clifton Rd., Birmingham
Lapp, Charles	7817 McClellan, Utica
Lee, Thomas E.	13403 E. 13 Mile Rd., Warren
Levi, Charles	8262 E. Twelve Mile Rd., Warren
Lublin, Ann	21349 Kelly Rd., East Detroit
Maguire, Andrew J.	45569 Van Dyke, Utica
Marinelli, Ralph	8252 E. Twelve Mile Rd., Warren
Mark, Hansi	8236 E. 12 Mile Rd., Warren
Martin, Wm. L.	117 S. Main St., Romeo
Mattes, Max W.	18456 Wildemere, Detroit 21
Matthews, C., Jr.	14 Belleview, Mt. Clemens
Maxim, Edward S.	253 South Gratiot, Mt. Clemens
Mayer, Mary L.	22631 Greater Mack, St. Clair Shores
McGinty, John D.	243 S. Gratiot, Mt. Clemens
McMorrow, Kathryn	15341 Nine Mile Rd., East Detroit
Merametdjian, Krikor	22841 Vandyke, Warren
Merritt, Jule J.	36640 S. Gratiot Ave., Mt. Clemens
Messmer, Harold O.	7817 McClellan, Utica
Meyers, Sidney S.	28477 Hoover, Warren
Miller, Sidney S.	28477 Hoover Rd., Warren
Moore, Geo. F. (L)	69434 N. Forest, Richmond
Morris, Gerald W.	14 Belleview, Mt. Clemens
Mulligan, Philip T.	612 Monitor Leader Bldg., Mt. Clemens
Nance, Marion E.	33080 Garfield Rd., Fraser
Neiswander, Paul L.	Fisher Body Div. GMC, Warren
Nutting, Helen M.	22631 Greater Mack, St. Clair Shores
Ornstein, Charles	21701 Kelly Road, East Detroit
O'Shee, Vincent	8216 E. Twelve Mile Rd., Warren
Oughtred, Orville	26401 Harper, St. Clair Shores
Pacho, Marc	27075 Gail, Warren
Paris, Delmo A.	18801 E. Ten Mile Rd., Roseville
Parmelee, N. H.	52080 Van Dyke Ave., Utica
Perez, Florence	27075 Gail, Warren
Porretta, Anthony C.	16249 Fairfield, Detroit 21

Ramos, Antonio E..........29846 Schoenherr, Warren
Reitzel, Rufus H..........199 S. Gratiot Ave., Mt. Clemens
Reizen, Maurice S..........23700 Van Dyke Ave., Warren
Revere, Jos. O..........192 S. Gratiot Ave., Mt. Clemens
Rickman, Lewis D..........14 Howard, Mt. Clemens
Riddle, Charles B..........620 Eastland Prof. Bldg., Harper Woods
Rinkenberger, E. A..........243 S. Gratiot Ave., Mt. Clemens
Rivkin, Jos..........14 Belleview, Mt. Clemens
Rizzo, Albert..........21321 Harper, St. Clair Shores
Rooney, Robert..........23700 Van Dyke, Warren
Roth, Geo. E..........19136 Mendota Ave., Detroit 21
Rothman, Arthur M..........22422 Gratiot Ave., East Detroit
Rourke, Ronald E..........21503 Harper Ave., St. Clair Shores
Rousseau, Daniel L..........Monitor Leader Bldg., Mt. Clemens
Ruedisueli, C. A..........19 Breitmeyer Pl., Mt. Clemens
Rush, Wm. E..........25815 Harper, St. Clair Shores
Ryan, Jack..........23700 Van Dyke Ave., Warren
Ryan, Thomas E..........5518 Eastlawn, Detroit 13
Salot, Russell F..........67 Cass Ave., Mt. Clemens
Samet, Norman..........310 Monitor Leader Bldg., Mt. Clemens
Sarnacki, Carl J..........8425 Twelve Mile Rd. E., Warren
Scher, Jos. N..........130 Cass Ave., Mt. Clemens
Scher, Sydney..........132 Cass Ave., Mt. Clemens
Schmunk, Robert F..........136 Cass Ave., Mt. Clemens
Shawky, Yehya A..........8425 E. Twelve Mile Road, Warren
Shaya, Ezra S..........31170 Hoover, Warren
Sherbin, Herbert D..........12500 12 Mile Rd., Warren
Siegfried, Edward G..........229 S. Gratiot Ave., Mt. Clemens
Simmons, Milton F..........12500 E. Twelve Mile Rd., Warren
Sims, Wm. N..........229 S. Gratiot Ave., Mt. Clemens
Singer, Nelson..........22100 Gratiot Ave., East Detroit
Stanton, James..........225 S. Gratiot Mt. Clemens
Starbird, Wm. A..........8216 E. 12 Mile Rd., Warren
Starkman, Morris..........28477 Hoover, Warren
Steele, George H..........229 S. Gratiot, Mt. Clemens
Steinberger, Eugene..........23700 Van Dyke, Warren
Stepka, Joseph E..........7817 McClellan, Utica
Stief, Kirwin..........66 Riverview, Mt. Clemens
Stone, Elizabeth A..........The Manor House, Barbary Health near Paporley, Cheshire, England
Stone, Julius..........67 Cass Ave., Mt. Clemens
Stoyka, Charles..........21503 Harper, St. Clair Shores
Stryker, Oscar D..........43525 Elizabeth Rd., Mt. Clemens
Sturm, Fredk. A..........76 Lochmoor, Grosse Pointe 36
Suksta, Adolph W..........23250 Gratiot, East Detroit
Suzuki, M..........23700 Van Dyke, Warren
Thompson, Alfred A..........126 Cass Ave., Mt. Clemens
Tinkey, L. Leo..........8306 Twelve Mile Rd., Warren
Transue, David..........13403 E. 13 Mile Rd., Warren
Urbancic, William..........24605 Almont, East Detroit
Vaughn, Charles..........1223 Buckingham, Grosse Pointe Park
Weiss, Jack I..........23700 Van Dyke Ave., Warren
Whitley, Alec..........30233 Jefferson Ave., St. Clair Shores
Wilde, Maurice M..........5930 Chicago, Warren
Wiley, D. Bruce (L)..........46056 Cass Ave., Utica
Wilson, Norman R..........225 S. Gratiot Ave., Mt. Clemens
Witus, Carl..........21349 Kelly Rd., East Detroit
Wolf, Ervin..........17819 Homer St., Roseville
Wyte, Wm. C..........263 S. Gratiot Ave., Mt. Clemens
Yamasaki, Ken..........23700 Van Dyke, Warren
Zavela, Dan..........679 N. Renaud, Grosse Pte. Wds.
Zook, Mr. Gilbert E. (A)..........253 S. Gratiot, Mt. Clemens
Zucker, Norman..........27225 Little Mack, St. Clair Shores

MANISTEE COUNTY MEDICAL SOCIETY (130)

Futterer, Le Roy A..........Forest Clinic Bldg., Manistee
Garneau, Robt. R..........Forest Clinic Bldg., Manistee
Gunderson, Edw. P., Jr..........Greenbush St., Manistee
Hansen, Ernest C..........326 First St., Manistee
Kiley, James A..........310 9th St., Manistee
Konopa, John F..........57 Poplar St., Manistee
Miller, Ernest B..........326 First St., Manistee
Oakes, Ellery A. (R)..........576 Bryant Ave., Manistee
Ramsdell, Homer A. (L)..........398 River St., Manistee
Rosenow, K. G..........Forest Clinic Bldg., Manistee
Schwarz, Marlowe L..........Onekama
Schwing, Donald N..........Forest Clinic Bldg., Manistee
Wild, David A..........310 9th St., Manistee

MARQUETTE-ALGER COUNTY MEDICAL SOCIETY (134)

Acocks, James R..........Morgan Hgts. Sanat., Marquette
Amolsch, Arthur L..........1008 Bluff St., Marquette
Bennett, Arthur K. (L)..........1089 Palmetto Rd., Mt. Dora, Fla.
Bennett, Matthew C..........Medical Building, Marquette
Berry, Robt. F..........No address
Bertucci, Jos. P..........114 S. First St., Ishpeming
Bolitho, Thos. B..........Medical Bldg, Marquette
Carefoot, Rankin L..........St. Lukes Hospital, Marquette
Carter, James M..........1133 Market St., Parkersburg, W. Va.
Casler, Wilbur L. (L)..........131 E. Ridge St., Marquette
Celori, Luciano..........117 S. Front St., Marquette
Conley, Donal T..........1st Natl. Bank Bldg., Marquette
Cooperstock, Moses..........Medical Building, Marquette
Corcoran, Wm. A. (L)..........200 S. Main Street, Ishpeming
D'Adesky, R. G..........Med. Arts Bldg., Daytona Beach, Fla.
Drury, Chas. P. (R)..........416 E. Hewitt Ave., Marquette
Elzinga, Eugene R..........315 N. Front St., Marquette
English, John W..........Med Bldg., Marquette
Flores, R..........818 W. College Ave., Marquette
Green, Southgate J..........Gwinn
Hettle, Paul J..........5405 E. Bails Dr., Denver, Colo.
Hornbogen, Danl. P..........101 S. Front St., Marquette
Howe, Lloyd W. (L)..........101 S. Front St., Marquette
Huffman, Elston R..........427 W. College, Marquette
Humphrey, William C..........829 Croix Street, Negaunee
Jaedecke, Robt. G..........829 Croix, Negaunee
Kane, Elizabeth D..........418 W. Magnetic, Marquette
Knutson, Geo. O. (A)..........125 E. Main St., Negaunee
Koenig, Harry..........308 E. Pearl St., Ishpeming
Kronschnabel, E. F..........Medical Bldg., Marquette
Lambert, Warren C..........Medical Building, Marquette
Lexmond, M. J..........524 Mather Ave., Ishpeming
Lincke, E. T..........Medical Bldg., Marquette
Lyons, James W..........803 N. 3rd St., Marquette
Matthews, Norman L..........N. Mich. Child. Clinic, Marquette
Mudge, Thomas J..........Medical Building, Marquette
Mudge, Wm. A. (L)..........108 Ridge St., Negaunee
Narotzky, Archie S..........Miracle Circle, Ishpeming
Niemi, Osmo..........Box 151, Gwinn
Olson, Walter R..........Sand Point Rd., Munising
Pearson, Wallace G..........211 Savings Bank Bldg., Marquette
Pillote, Florence A..........26 Lakeview Drive, Marquette
Pillote, John F..........Medical Bldg., Marquette
Rice, Franklyn G..........Northern Mich. Univ., Marquette
Rosenbaum, Louis..........540 E. Division, Ishpeming
Sabin, Fredk. C..........101 S. Front St., Marquette
Schmidt, Merle C. (A)..........Medical Bldg., Marquette
Schroeder, W. Gene..........745 Mathe Ave., Ishpeming
Schweinsberg, Sara K. D. (A)..........507 Bemis Rd., RFD, Saline
Tobin, James F., Jr..........724 Elliott Ave., Ishpeming
Van Riper, Paul (L)..........Champion
Wall, David R..........Aitamont & Fisher, Marquette
Williams, Reginald G..........524 Mather St., Ishpeming
Wilson, George M., Jr..........Medical Building, Marquette
Wright, Kenneth C..........Medical Building, Marquette

MASON COUNTY MEDICAL SOCIETY (138)

Bacon, Herbert G., Jr..........101 N. Main, Scottville
Boldyreff, Ephraim B..........Custer
Boon, A. Floyd..........203 N. Ferry, Ludington
Carney, John R..........202 N. Park St., Ludington
Carney, Ruth V. C..........202 N. Park Ave., Ludington
Castellani, R. J..........P.O. Box 349, Ludington
Clark, Harry L. (L)..........510 N. Lakeshore Dr., Ludington
Craymer, Austin..........420 N. Rath, Ludington

Ewing, R. L.........600 Tinkham Ave., Ludington
Hoffman, Howard B.........7418 Golfwood Rd., Ludington
Kellawan, Karl K.........Scottville
Kleinschmidt, Gladys J.....401 E. Ludington Ave., Ludington
Martin, Wm. S.........107 Ludington, Ludington
Mayer, Gerry.........600 Tinkham Ave., Ludington
Morrow, Wm. J.........119 N. James St., Ludington
Ostrander, Robt. A.........2945 E. First, Tucson, Ariz.
Paukstis, Chas. A.........111 E. Court St., Ludington
Sutter, Wm. F.........220 S. James St., Ludington

MECOSTA-OSCEOLA-LAKE COUNTY MEDICAL SOCIETY (142)

Bruggema, Jacob.........Main St., Evart
Franklin, Benj. L. (L).........Remus
Haldeman, Jack.........1014 S. State St., Big Rapids
Hickox, Leland A.........1014 S. State St., Big Rapids
Kilmer, Paul B.........Reed City
Kowaleski, Edward H.........Remus
Lincoln, Norman V.........Reed City
Merlo, Frank A.........206 S. Michigan St., Big Rapids
Nelson, Lorenzo R.........RFD 1, Baldwin
Pratt, Gordon C.........Ferris Institute, Big Rapids
Tyson, James L.........1014 South State St., Big Rapids
Van Auken, Edward W.........229 S. Warren, Big Rapids
Walters, James E.........1014 S. State St., Big Rapids
White, John A.........121 S. Michigan St., Big Rapids

MEDICAL SOCIETY OF NORTH CENTRAL COUNTIES (150)

Baker, Ophelia P.........199 Fairview, West Branch
Baker, Thomas A.........199 Fairview, West Branch
Barstow, Richard G.........Gaylord
Blaha, Vernon B.........Grayling
Boehm, John D. (R).........West Branch
Bontrager, W. E.........Mio
Christensen, D. E.........N. Mich. TB San., Gaylord
Clippert, C. G. (R).........308 Michigan Ave., Grayling
Coulter, Keith D.........Box 138, Alden
Crandell, Clare H. (R).........West Branch
Dosch, Paul.........Grayling
Forney, Fred A. (L).........Saginaw County Hosp., Saginaw
Godfroy, Bernard.........Roscommon
Hayes, Louis F.........Gaylord
Henig, Benj. E.........Grayling
Howarth, Thos. W.........Gladwin
Jardine, Hugh M.........West Branch
Kieler, George E.........Roscommon
Libke, Robert S.........Gaylord
Martens, Elvina.........Box 17, Fairview
Mills, Georgia.........Lake City
Oppy, Charles L.........Roscommon
Peckham, Richard C.........Gaylord
Potvin, Clifford D.........Grayling
Rusak, R. D.........Gladwin
Schaiberger, Geo. L.........West Branch
Timreck, Harold A.........Gladwin
Van Oosten, Howard E.........117 Burgess, West Branch
Wiegerink, L. T.........West Branch

MENOMINEE COUNTY MEDICAL SOCIETY (146)

Agneberg, Nils O.........531 1st St., Menominee
Brukardt, Herman R.........534 First St., Menominee
Dewane, Francis J.........413 10th Ave., Menominee
Glickman, L. Grant.........958 First St., Menominee
Gonty, Arthur.........St. Joseph Lloyd Hosp., Menominee
Heidenreich, John R.........Daggett
Hopson, George H.........19186 Santa Barbara, Detroit
Hopson, Patricia C.........19186 Santa Barbara, Detroit
Jones, Wm. S. (L).........1146 Tenth Ave., Menominee
Jones, Wm. S., Jr.........1146 Tenth Ave., Menominee
Kerwell, Karm C. (L).........P.O. Box 17, Stephenson
Olson, Robt. C. (A).........1713 22nd St., Menominee
Towey, John W. (L)....1717 Orchid Lane, Middleton, Wisc.

MIDLAND COUNTY MEDICAL SOCIETY (154)

Athay, R. M. (R).........4622 Concord Ct., Midland
Benjamin, Mac B.........307 Cass St., Sanford
Bernier, Jos. A.........218 E. Railway, Sanford
Blackhurst, J. F.........2715 Ashman St., Midland
Blackhurst, Robt. T.........Blackhurst Bldg., Midland
Bowsher, Robt. E.........4005 Orchard Dr., Midland
Bridge, Robt. G.........2715 Ashman, Midland
Bulmer, Dan J.........2707 Ashman St., Midland
Bush, Raymond C.........808 W. Sugnet, Midland
Buskirk, Maurice D.........110 W. Sugnet, Midland
Cline, J. Daniel.........504 Linwood Dr., Midland
Devlin, James A.........115 Jerome, Midland
Ellis, Ruth.........2510 Ashman, Midland
Fields, Dozier N., Jr.........515 W. Main St., Midland
Gay, Harold H.........Dow Chemical Co., Midland
Goethe, Roy M.........110 W. Sugnet, Midland
Gordon, Harold L.........Dow Chemical Co., Midland
Grant, Robert.........116 Harold St., Midland
Grewe, Norman C.........501 E. Pine St., Midland
Haberstroh, Colleen.........3710 Applewood, Midland
Harrigan, William E.........2706 Louanna, Midland
Heffernan, D. D.........402 Dartmouth, Midland
Holder, Benj. B.........Dow Chem. Co. Med. Dept., Midland
Howe, Irvin M.........110 W. Sugnet, Midland
Howell, Richard H.........2719 Ashman, Midland
Ittner, Martin J.........217 N. Saginaw Rd., Midland
Kramer, Chas. G.........Box 469, Dow Chemical, Midland
Kremski, John A.........Midland Hospital, Midland
Kwast, Harold A.........2715 Ashman, Midland
Linsenmann, Karl W.........2604 Manor Dr., Midland
Marks, V. A.........2706 Louanna, Midland
Maynard, Wm. A.........208 N. Fourth, Coleman
Meisel, Edward H., Jr.........Masonic Bldg., Midland
Mesaros, Michael P.........44 Ashman Circle, Midland
Moench, G. Fredk.........147 Center St., Sanford
O'Hora, Bernard A.........110 W. Sugnet Rd., Midland
Ohorodnik, Julius M.........109 Capitol Drive, Midland
Pike, Melvin H.........224 E. Larkin, Midland
Pollock, Robert.........2707 Ashman St., Midland
Poznak, Leonard A.........4005 Orchard Dr., Midland
Randolph, Stephen H.........201 E. Ellsworth St,. Midland
Redmon, William B.........115 Jerome, Midland
Sanislou, Charles A.........2707 Ashman St., Midland
Schoff, Charles A.........2706 Louanne, Midland
Shriner, John W.........902 E. Ashman, Midland
Smock, Sidney N.........3911 Moorland Drive, Midland
Stewart, Richard.........Dow Chemical Co., Midland
Thamarus, W. E., Jr.........5801 Highland Dr., Midland
Towsley, Wilbur D.........515 W. Main St., Midland
Ulmer, George.........4005 Orchard, Midland
Westphal, Harry O.........3102 Swede Rd., Midland
Willison, Chas. H.........122 Townsend St., Midland
Yobst, G. James.........2719 Ashman, Midland

MONROE COUNTY MEDICAL SOCIETY (158)

Ames, Florence D.....2 W. Noble Ave., Monroe
Barrett, C. D., Sr.....Court House, Monroe
Black, Charles E.....721 N. Macomb St., Monroe
Blakey, Leonard C.....745 N. Monroe St., Monroe
Bond, Wm. W.....222 N. Monroe St., Monroe
Burroughs, J. J.....745 N. Monroe St., Monroe
Cigany, Zoltan B.....Carleton
Clark, Bruce.....8308 Lewis Ave., Temperance
Diehl, George Z.....721 N. Macomb, Monroe
Douglas, Dale W.....124 Cole Rd., Monroe
Dranginis, E. J.....Monroe Hospital, Monroe
Ewing, Robt. T.....130 Maple Blvd., Monroe
Flanders, John P.....31 Washington St., Monroe
Frary, Reginald A.....505 Strasburg, Monroe
Freud, John W.....1262 N. Macomb St., Monroe
Golden, Jean Dace.....304 Washington St., Monroe
Hensel, Hilda M.....12 E. 4th St., Monroe
Hnatczuk, Nicholas.....8078 Summerfield, Lambertville
Johnson, A. Esther.....751 N. Monroe St., Monroe
Kelso, S. Newton, Jr.....116 Cole Rd., Monroe
King, John R.....12 East 4th St., Monroe
Laboe, Edward W.....424 Hollywood, Monroe
Lammers, Gerald P.....Ida
Liedel, Warren J.....136 Cole Rd., Monroe
Loan, G. B.....429 N. Monroe St., Monroe
Long, Edgar C.....1310 N. Macomb St., Monroe
Lusher, William T.....8308 Lewis Ave., Temperance
McGeoch, Reginald W. (L).....718 N. Macomb St., Monroe
McMillin, John H.....423 E. Elm St., Monroe
Meier, Walter A.....134 Cole Rd., Monroe
Middleton, W. S.....219 W. Front St., Monroe
Ozdaglar, Mehmet N.....721 N. Macomb, Monroe
Pinkus, Hermann K. B.....12 E. 4th St., Monroe
Reisig, Albert H.....1 S Monroe St., Monroe
Sisman, Bernard.....130 Cole Rd., Monroe
Stephenson, Joy O.....721 N. Macomb St., Monroe
Streicher, Robt. G.....729 N. Monroe St., Monroe
Tomlinson, Ledyard T.....8718 Main St., Newport
Wagar, Spencer H.....31 Washington St., Monroe
Weeks, Vernon L.....326 N. Monroe, Monroe
Wilkins, Rolland W.....118 Cole Rd., Monroe
Williams, Robt. J.....31 Washington St., Monroe
Wood, Russell J.....2021 Saturn Rd., Garland, Texas

MUSKEGON COUNTY MEDICAL SOCIETY (162)

Aardema, Austin A.....1129 Peck St., Muskegon
Allen, Richard T.....768 W. Broadway, Muskegon Heights
Alt, William J.....Medical Arts Center, Muskegon
Annessa, G. W.....Medical Arts Center, Muskegon
Askam, Ralph F.....Medical Arts Center, Muskegon
Atkinson, Annie L.....R. 1, Montague
August, Ralph V.....72 E. Broadway, Muskegon Heights

Barnard, Helen S.....1382 E. Airport Rd., Muskegon
Barnes, James W.....102 Professional Bldg., Montague
Barnett, James M.....2416 Peck St., Muskegon Heights
Benedict, Arthur L., Jr.....22 W. Southern Ave., Muskegon
Bloom, Robt. E.....Medical Arts Center, Muskegon
Bolthouse, Robt. E.....2101 Peck St., Muskegon Heights
Bond, Wm. H.....1282 Arthur St., Muskegon
Boyd, De Vere R.....1735 Peck St., Muskegon
Boyd, Jack L.....450 W. Western Ave., Muskegon
Bradshaw, Park S.....Medical Arts Center, Muskegon
Bultema, James H.....1470 Peck St., Muskegon
Busard, J. Max.....1200 Ransom, Muskegon
Busard, Thos. R.....Medical Arts Center, Muskegon

Carlson, Mr. James C. (A).....2060 Belmont, Muskegon
Chapin, Wm. S. (A).....2136 Sanford, Muskegon Heights
Christophersen, J. W.....1276 Lake Shore Dr., Muskegon
Clapp, Henry W.....202 Westgate Medical Twr., Muskegon
Clifford, James D. (A).....452 Maple, Plymouth
Closz, Harold F. (L).....1727 Jefferson St., Muskegon
Clowater, Robert A.....1092 Holton Rd., Muskegon
Cornell, Homer E.....870 N. Second, South Muskegon
Crawford, John W., Jr.....1470 Peck St., Muskegon
Cronick, Anne B.....435 Whitehall Rd., Muskegon

Dart, Dorothy O. (A).....428 W. Franklin, Salisbury, N. C.
Dasler, Adolph F.....1507 Peck St., Muskegon
De Leeuw, Henry.....4090 Higate Rd., Muskegon
Diskin, Frank.....1324 Marquette Ave., Muskegon
Dykhuizen, H. D.....289 W. Western Ave., Muskegon

Ellis, Nicholas J.....1891 Lake Shore Dr., Muskegon
Engstrom, Albert D.....117 W. Colby, Whitehall

Farmer, John C.....Medical Arts Center, Muskegon
Fillingham, Enid (R).....1034 Giles Rd., Muskegon
Findorff, William G.....Medical Arts Center, Muskegon
Fleischmann, Chas. B. (L).....1573 Jefferson St., Muskegon
Fles, Robt. J.....1715 Peck St., Muskegon
Folsom, John D.....1706 Peck St., Muskegon
Frandsen, Philip H.....1470 Peck St., Muskegon
Fugate, E. M.....Medical Arts Center, Muskegon

Gaikema, Everett W. (R).....605 First St., North Muskegon
Garber, Frank W., Jr.....1732 Peck St., Muskegon
Garber, Frank W.....235 Monroe Ave., Muskegon
Garrison, Robt. E., Jr.....126 W. Webster Ave., Muskegon
Giese, Douglas H.....204 Mich. Theater Bldg., Muskegon
Gillard, James L.....1642 Peck St., Muskegon
Goltz, Martha H. (L).....Montague
Griffith, Robt. M.....966 W. Broadway, Muskegon Heights

Hack, Donald W.....Medical Arts Center, Muskegon
Hanley, Wm. J.....315 W. Clay Ave., Muskegon
Harryman, James E.....1200 Ransom St., Muskegon
Hartwell, Shattuck W.....450 W. Western Ave., Muskegon
Harvey, John G. Klemm.....Mercy Hospital, Muskegon
Heneveld, John (R).....Brasstown, N. C.
Heneveld, Robt. G.....1470 Peck St., Muskegon
Hennessy, Mary E. (A).....1200 Ransom St., Muskegon
Herald, Osbie J.....1075 Jefferson St., Muskegon
Holly, Leland E.....889 N. Second St., Muskegon
Holly, Leland E., II.....889 N. Second St., Muskegon
Hornbeck, Wm. J.....1200 Ransom St., Muskegon
Huntley, Richard A.....1704 W. Sherman Blvd., Muskegon

Jesson, Robt. M.....1200 Ransom St., Muskegon
Johnston, E. H.....889 N. Second St., Muskegon
Joistad, Arthur H., Jr.....889 N. Second St., Muskegon

Kane, Thos. J. (M).....2086 Leimert Blvd., Oakland 2, Calif.
Kay, Cecelia S.....1533 Peck St., Muskegon
Keilin, Marie (L).....307 Liberty Life Bldg., Muskegon
Kerr, Howard J.....3054 Henry St., Muskegon
Kislov, Richard.....1810 Ruddiman Ave., N. Muskegon
Kleaveland, Ingram J.....1670 Peck St., Muskegon
Krenz, Marlin P.....Hackley Union Bk. Bldg., Muskegon

Lange, Eugene W.....337 N. Muskegon Blvd., Muskegon
Lapham, Landon M.....123 W. Colby, Whitehall
Lauretti, Emil J.....Medical Arts Center, Muskegon
Lauretti, L. A.....936 Second St., Muskegon
Laurin, Vilda S. (L).....Medical Arts Center, Muskegon
Le Fevre, Geo. L., Jr. (R).....726 Lake Dr., North Muskegon
Le Fevre, Wm. M.....315 W. Clay Ave., Muskegon
Lemmen, Lloyd J.....1724 Peck St., Muskegon
Leonard, Mr. A. T. (A).....435 Whitehall Rd., Muskegon
Loder, Leonel L.....289 W. Western Ave., Muskegon
Lowry, Robert A.....1470 Peck St., Muskegon

Maire, Lewis E.....1633 Peck St., Muskegon
Mandeville, C. B. (L).....5311 N. Bristol, Tacoma, Wash.
Maples, Douglas E.....1669 Peck St., Muskegon
Marrs, Jack Winton.....Med. Arts Bldg., Muskegon
McNair, John N.....936 Second St., Muskegon
Medema, Paul E.....1017 Sanford St., Muskegon
Meengs, Marvin B.....1725 Peck St., Muskegon
Miller, Phillip L.....1755 Peck St., Muskegon
Mulder, Lambertus.....Medical Arts Center, Muskegon

Oden, C. L. A. (L).....Medical Arts Center, Muskegon
Osland, Richard R.....889 N. Second St., Muskegon

Parsons, Frank W.....315 W. Clay Ave., Muskegon
Paterson, Lester C.....1643 Peck St., Muskegon

Peterson, Wm. F..........1094 Jefferson St., Muskegon
Pettinga, Frank L..........1603 Peck St., Muskegon
Prentice, Edwin W..........1017 Sanford St., Muskegon
Risk, Robt. D..........1160 Ransom St., Muskegon
Sanden, Howard V..........1643 Peck St., Muskegon
Scholle, Norbert W...204 Westgate Medical Twr., Muskegon
Shebesta, Emil M..........Medical Arts Center, Muskegon
Smith, Robert E..........Medical Arts Center, Muskegon
Steffee, William P..........1810 Ruddiman Ave., N. Muskegon
Stubbart, F. James..........2416 Peck St., Muskegon Heights
Stuk, Ronald L..........Medical Arts Center, Muskegon
Swanson, Raymond E.....1315 Ruddiman Ave., N. Muskegon
Sweda, George P..........Health Dept. Co. Bldg., Muskegon
Swedenburg, Robt. D..........1470 Peck St., Muskegon
Swenson, Leland L..........1706 Peck St., Muskegon
Tellman, H. Clay..........302 Med. Arts Center, Muskegon
Thieme, Siegfried W. (L)........12213 Stafford St., Ravenna
Thornton, Eugene S. (L)....301 E. Circle Dr., N. Muskegon
Torrey, R. K..........Westgate Medical Bldg., Muskegon
Toy, Chas. M..........1067 Pine St., Muskegon
Tyler, Wm. H..........1435 Peck St., Muskegon
Vandervelde, C. A..........1470 Peck St., Muskegon
Vangelder, Wm. C..........Medical Arts Center, Muskegon
Voikos, Geo. A..........179 Strong Ave., Muskegon
Wagenaar, Edward H..........3054 Henry St., Muskegon
White, Warren G., Jr..........307 Westgate Medical Twr., Muskegon
Wiersma, Silas C..........Medical Arts Center, Muskegon
Wildgen, Bernard C..........Medical Arts Center, Muskegon
Wilke, Carl A. (R)..........(Address Unknown)
Williams, Dale L..........1692 Peck St., Muskegon
Williams, Edward V........2501 Baker St., Muskegon Heights
Wilson, B. David (A)..........15428 Archdale, Detroit 27
Wohlrabe, J. C..........Medical Arts Center, Muskegon
Young, Malcolm C..........1700 Clinton St., Muskegon

NEWAYGO COUNTY MEDICAL SOCIETY (166)

Decker, J. C..........Grant
Deur, Theodore R..........Grant
De Young, Jess..........111 W. Dayton, Fremont
Emerick, Robt. W..........Box 147, Fremont
Geerlings, Lambert J. (L)........20 N. Division St., Fremont
Klein, J. Paul..........P.O. Box 111, Fremont
Masters, Brooker L..........111 W. Dayton, Fremont
Moore, Hugh R. (L)..........Newaygo
O'Neill, John W. (R)......Dist. Health Dept. 5, White Cloud
Painter, Robert..........Grant
Paxton, Robt. E..........40 W. Sheridan, Fremont
Pedelty, Norman..........Newaygo
Vanden Berg, Tunis..........20 N. Division Ave., Fremont
Veenschoten, Girard..........Hesperia

NORTHERN MICHIGAN MEDICAL SOCIETY (170)

Allen, Robt. F..........Lockwood Hosp., Petoskey
Alm, Bernhard T..........418 Petoskey St., Petoskey
Blum, Benj. B..........1208 E. Mitchell, Petoskey
Burns, Dean C..........215 Division, Petoskey
Christie, Joseph P..........204 W. State, Mancelona
Conkle, Guy C. (L)..........Masonic Bldg., Boyne City
Conklin, Frederic L. (A)..........No address
Connaughton, P. J..........314 Spencer, Petoskey
Conti, Jos. B..........924 E. Mitchell St., Petoskey
Conway, Wm. S..........910 E. Mitchell, Petoskey
Crippen, Edward F. (A)..4908 N. Carmel Dr., Mobile, Ala.
Dawson, William A..........Burns Clinic, Petoskey
Drake, Gerald..........511 Waukazoo, Petoskey
Elliott, Dean C..........Arlington Heights, Petoskey
Foster, Bradford S..........11110 Kalamazoo, Petoskey
Frye, Sanders A..........Burns Clinic, Petoskey
Fulmer, Roger C..........9838 Peninsula Dr., Traverse City
Grate, Lawrence E..........112 Clinton, Charlevoix
Hegener, Aloysius J..........1020 Howard, Petoskey
Homsi, Rateb..........802 S. Main St., Cheboygan
Kirk, Thomas R..........West Sheridan Rd., Petoskey
Knecht, Richard A..........226 Park Ave., Petoskey
Kutcipal, R. A..........1018 Lindell, Petoskey
Larson, Walter E..........456 S. Huron, Cheboygan
Lentini, Nicholas..........Cheboygan
Lignell, John H..........Rt. 3, Division St., Charlevoix
Litzenburger, A. F..........411 Pearl St., Boyne City
Martin, Robt. G..........707 Bridge, Charlevoix
Mateskon, Victor S..........Sunset Blvd, Petoskey
Mayne, Frederick C. (L)..........P.O. Box 387, Cheboygan
McCullough, W. L..........115 Clinton, Petoskey
McEnroe, John E..........1005 E. Mitchell, Petoskey
McKnight, Robt. D..........Lincoln Place, Petoskey
Mertz, Joanne E..........Resort Pike, Petoskey
Pearson, Robt. E..........215 Water St., Boyne City
Postle, Jack R..........Arlington Heights, Petoskey
Rauch, Carl T..........420 Riverside Dr., Cheboygan
Reus, Leonard W..........226 Park Ave., Petoskey
Rodger, John R..........Bellaire
Saltonstall, G. B. (L)..........112 Clinton St., Charlevoix
Savory, John H..........East Jordan
Schaefer, Joseph C..........1133 Valley View, Petoskey
Shanahan, Robt. E..........1015 Lindell Ave., Petoskey
Sheets, John A..........1111 E. Mitchell, Petoskey
Smith, James R..........901 Spruce St., Petoskey
Snide, Rollin F..........125 N. Main St., Cheboygan
Spengler, John R..........1111½ E. Mitchell, Petoskey
Stringham, James R. (L)..........225 Backus St., Cheboygan
Tanton, John H..........Burns Clinic, Petoskey
Taylor, Robt. M..........Lincoln Place, Petoskey
Uhlich, Gustav A..........E. Mitchell Rd., Petoskey
Van Dellen, Jerrian..........Water St., East Jordan
Webster, Jean H..........200 Sunset St., Petoskey
Weburg, Kathryn D..........Burns Clinic, Petoskey
Zipf, Charles..........Douglas Lake, Pellston

OAKLAND COUNTY MEDICAL SOCIETY (174)

Abbott, Vernon C..........1405 Pontiac St. Bk., Pontiac
Adair, Robin..........800 S. Adams, Birmingham
Albert, Donald G..........1665 Twelve Mile Rd., Berkley
Albrecht, Robt. W.........2111 Cass Lake Rd., Keego Harbor
Alexander, Joseph B.........2075 E. 14 Mile Rd., Birmingham
Altshuler, Ira M. (L)..........17600 W. 8 Mile, Southfield
Anaya, Jacinto M. (A)..........Pontiac State Hosp., Pontiac
Andrakovich, F..........Pontiac State Hosp., Pontiac
Arena, Joseph A., Jr.......31815 Southfield Rd., Birmingham
Arnkoff, Harry..........140 Illinois, Pontiac
Ashare, Raymond..........35 S. Johnson, Pontiac
Aulie, Hal G..........420 Washington Sq. Bldg., Royal Oak
Awes, Lorraine E..........35 S. Johnson, Pontiac
Baier, Kurt..........2186 Garland, Pontiac 19
Baker, Frederick A. (L)..........248 S. Paseo Lobo, Green Valley, Arizona
Bannow, Robt. J..........880 Woodward Ave., Pontiac
Barker, Chas. P..........214 Wabeek Bldg., Birmingham
Barker, Howard B. (L)..........880 Woodward Ave., Pontiac
Barlow, Peter P..........31815 Southfield Rd., Birmingham
Barnes, Donald J. (L)..717 W. Ten Mile Rd., Pleasant Ridge
Barr, Norman L.....965 Orchard Ridge Rd., Bloomfield Hills
Barrett, John L..........800 S. Adams, Birmingham

Barron, Robert A.........4256 Pontiac Trail, Orchard Lake
Barsch, Henry J.........17579 Murray Hill, Detroit
Bauer, Bruce D.........22643 Stephenson Hwy., Hazel Park
Bauer, Edward G.........101½ N. Saginaw, Pontiac
Bauer, Ernest W., Sr.....22643 Stephenson Hwy., Hazel Park
Bauer, Ernest W., Jr.....22643 Stephenson Hwy., Hazel Park
Bauer, Franz.........909 Woodward Ave., Pontiac
Baylis, Shelby M.........35 S. Johnson, Pontiac
Beattie, Willard G. (R).........2500 Sample Rd., Pompano Beach, Fla.
Beck, Otto O. (L).........308 Wabeek Bldg., Birmingham
Becker, Paul M.........1890 Southfield Rd., Birmingham
Belknap, Warren F.........1809 S. Main St., Pleasant Ridge
Benoit, Merrill P.........Pontiac Mtr., Div. GMC, Pontiac
Berg, Richard M.........880 Woodward Ave., Pontiac
Berger, Chas. J.........17220 W. Eight Mi. Rd., Southfield
Berkman, Ruth (A)......31555 W. Ten Mile Rd., Farmington
Berman, Bernard D.........1200 N. Telegraph Rd., Pontiac
Berman, Gilbert M.........22100 Coolidge, Oak Park
Beuker, John T.........1100 N. Woodward Ave., Birmingham
Beyer, Hans A.........5675 Kolly Rd., Birmingham
Birkelo, Carl H.........4680 Dixie Hwy., Drayton Plains
Blakeney, Gerald E.........17 Utica Rd., Pontiac 11
Blanchard, Gerald E.........GMC Pontiac Mtr. Div., Pontiac
Blue, Jane.........19125 Hillcrest, Birmingham
Bockrath, Henry M. (A)......Pontiac State Hospital, Pontiac
Boesky, Malcolm D.........26789 Woodward Ave., Huntington Woods
Boileau, Thornton I.........2075 E. 14 Mile Rd., Birmingham
Bookmyer, Robt M.........31815 Southfield Rd., Birmingham
Boucher, Roman E.......4200 N. Woodward Ave., Royal Oak
Bowers, Chas. L.........909 Woodward Ave., Pontiac
Brady, Neal C.........19040 Riverside Dr., Birmingham
Bronson, Wm. W.........28119 John R St., Madison Heights
Brown, Arnold L.........35 S. Johnson, Pontiac
Browne, Richard T. (A).........2013 Houstonia, Royal Oak
Bryan, Henry G.........22100 Coolidge, Oak Park
Bryant, F. W.........201 Washington Sq. Plaza, Royal Oak
Budd, Alexander S. Z...3511 Lakecrest Dr., Bloomfield Hills
Buehrig, Robert.........5790 M 15, Clarkston
Bullard, R. W., Jr.........5790 M 15, Clarkston
Bunto, William G.........7320 S. State Rd., Goodrich
Burger, John H.........31815 Southfield Rd., Birmingham
Burgess, Bruno.........29250 Longview St., Warren
Burke, Chauncey G.........35 W. Huron St., Pontiac
Burns, Theodore A. (A).........Pontiac Gen. Hosp., Pontiac
Byberg, Robt. A.........420 Washington Sq. Plaza, Royal Oak
Cabrera, G. P.........420 Washington Sq. Plaza, Royal Oak
Calhoun, Ethel T.........707 Lakeview Ave., Birmingham
Calkins, Edwin A.........865 N. Lapeer Rd., Lake Orion
Campbell, K. N.........1465 Cedar Bend Dr., Bloomfield Hills
Campbell, Malcolm D. (R).........216 Washington Sq. Pl., Royal Oak
Capili, Apolinario.........32595 Grand River Ave., Farmington
Carlisle, Jos. D.........1810 Woodward Ave., Birmingham
Carpenter, G. B., Jr.........622 N. Woodward, Birmingham
Carrow, Joyce M. (A).........1469 Highmoor Highway, Bloomfield Hills
Castedo, Nicador F.......126 Barrington Rd., Bloomfield Hills
Cefai, Anthony F.........35 S. Johnson, Pontiac
Chandler, Douglas.........1890 Southfield Rd., Birmingham
Chandler, Jos. H.........309 Northland Med Bldg., Southfield
Cheng, James T. (A)......Letchworth Village, Thiells, N. Y.
Cherup, Nicholas.........Pontiac General Hosp., Pontiac
Childers, Merle A.........320 Walnut, Rochester
Chisa, Neldagae....26711 Woodward Ave., Huntington Wds.
Christensen, Willis L.....109 W. Eleven Mile Rd., Royal Oak
Clair, Alvin H.........31815 Southfield Rd., Birmingham
Clarke, Harriet A.........130 Seminole, Pontiac
Cline, Alan L.........4299 Roseberry, Drayton Plains
Cobb, Thos. H.........880 Woodward Ave., Pontiac
Cohen, Jack J.........17226 Adrian Rd., Southfield
Cohen, Lewis.........26602 Dundee Rd., Huntington Woods
Collins, Edward F., Jr.........35 W. Huron St., Pontiac
Condon, Frank J.........2401 E. Fourth, Royal Oak
Conner, Edward D.........3856 S. Miller Way, Birmingham
Conrad, Cecil D.........3027 N. Woodward Ave., Royal Oak
Cooksey, Norton J.........801 S. Adams Rd., Birmingham
Cooley, Roy V.........318 S. Blvd. West, Pontiac
Cooper, Edmond L.......4200 N. Woodward Ave., Royal Oak
Cooper, Robt. S.........3027 N. Woodward Ave., Royal Oak
Corrigan, K. E., Ph.D. (A).........Wm. Beaumont Hospital, Royal Oak
Coskey, Ralph J.........22100 Coolidge, Oak Park
Coucke, Henry O.........1148 S. Woowdard Ave., Royal Oak
Counts, Robert W.........302 Walnut St., Rochester
Crum, Roger E.........35 S. Johnson, Pontiac
Cudney, Ethan B. (L).........35 S. Johnson, Pontiac
Cutler, Wm. M.........800 S. Adams Rd., Birmingham
Dahlgren, Carl W.........3023 Orchard Lake, Keego Harbor
Darling, C. G., Jr.........880 Woodward Ave., Pontiac
Dayton, Richard C.........427 W. University Dr., Rochester
Deighton, Murray N.........23023 Orchard Lake Rd., Farmington
Delaney, Malcolm J....23023 Orchard Lake Rd., Farmington
De Lawter, Hilbert H.........925 E. Maple Rd., Birmingham
Delevie, Jaap B.........640 Riker Bldg., Pontiac
Deutsch, Wm. L.........600 W. 11 Mile Rd., Royal Oak
De Vito, H. Louis.........3115 Angelus Dr., Pontiac
Ditto, William R.........Pontiac General Hosp., Pontiac
Dobski, Edwin J.........909 Woodward Ave., Pontiac
Doerr, Louis E., Jr.........1413 S. Washington, Royal Oak
Donnelly, Wm. J.........2561 Elizabeth Lake Rd., Pontiac
Dooley, Wm. D.........35 S. Johnson St., Pontiac
Dorostkar, Massoud.........150 Bird Apt. 18, Birmingham
Dorsey, John M., Jr.......31815 Southfield Rd., Birmingham
Drew, Dale R.........909 Woodward Ave., Pontiac
Drogowski, Edward J.........320 Walnut St., Rochester
Duane, William O...909 East 12 Mile Rd., Madison Heights
Duhamel, Peter A.........25000 W. Ten Mile Rd., Southfield
Dunlap, Gregg L.....2870 Orchard Lake Rd., Keego Harbor
Dunn, Lewis E.........3924 Twelve Mile Rd., Berkley
Durak, Gerald G.........1809 S. Main St., Pleasant Ridge
Durocher, Normand E.........35 S. Johnson, Pontiac
Dustin, Robt. W.........1314 W. Lincoln, Birmingham
Ekelund, Clifford T. (L).........35 W. Huron St., Pontiac
Elder, Edward E., Jr.........1116 Voorheis, Pontiac
Endress, Z. F., Jr.........35 S. Johnson, Pontiac
Engel, John B. (R).........235 Linden Rd., Birmingham
Ensroth, Jack F.........1100 N. Woodward, Birmingham
Esslinger, John O.........622 N. Woodward Ave., Birmingham
Evseeff, Geo. S.........2685 Amberly Rd., Birmingham
Farah, Jalil.........146 E. Hickory Grove Rd., Bloomfield Hills
Fargher, Robert A.........660 South Boulevard E., Pontiac
Fenton, James L. (A)..1615 Birmingham Blvd., Birmingham
Fidler, Wm. F.........Oakland Co. Sanatorium, Union Lake
Fink, L. Jerome.........500 W. Huron St., Pontiac
Finkell, Lawrence J.........15231 W. Seven Mile Rd., Detroit 35
Fishman, Gordon R. A.........25721 Coolidge, Oak Park 37
Fitzpatrick, F. J.........92 Spokane Dr., Pontiac
Flaharty, Wm. J.........25000 W. Ten Mile Rd., Southfield
Flick, John R.........120 W. Second St., Royal Oak
Forest, Jean L.........4540 Pickering, Birmingham
Fox, Ralph M.........800 S. Adams Rd., Birmingham
Furlong, Harold A. (L).........35 S. Johnson Ave., Pontiac
Fushman, John A.......4200 N. Woodward Ave., Royal Oak
Gaba, Howard B.........17328 Ohio, Detroit 21
Gaber, Ben.........10831 W. Ten Mile Rd., Oak Park 37
Gadbaw, Jos. J.........23607 Farmington Rd., Farmington
Gaensbauer, F.........1965 N. Hammond Lake Dr., Pontiac
Gagliardi, R. A.........880 Woodward Ave., Pontiac
Gaimari, Frank A. (A).........36 N. Johnson, Pontiac
Galens, Gilbert J.........No address
Galpin, Richard R.........525 Southfield Rd., Birmingham
Garber, Max J.........23023 Orchard Lake Rd., Farmington
Gariepy, Bernard F.........120 W. 11 Mile Rd., Royal Oak
Gates, Edward M.........35 S. Johnson, Pontiac
Gates, Joann M.........861 W. Huron St., Pontiac
Gatley, Cleo R. (R).........97 N. Perry St., Pontiac
Gatley, Leslie W.........445 W. Huron St., Pontiac 14
Gause, Richard C.........31815 Southfield Rd., Birmingham
Gayles, Carlos B. (A).........51 Seminole St., Pontiac
Gehringer, Norman F.........880 Woodward, Pontiac
Geist, Edgar J., Jr.........1500 Walton Blvd., Rochester
Gell, James W.........35 S. Johnson Ave., Pontiac
Gelstein, Lazaro.........909 Woodward Ave., Pontiac
Gerls, Frank B. (L).........602 Pontiac Bank Bldg., Pontiac
Gibson, Wellington C.........206 E. Commerce, Milford
Gill, Matthew J.........1030 Riker Bldg., Pontiac
Glen, Harold.........26684 Grand River, Detroit
Goerner, Dorothy M. (A).........338 Pilgrim, Birmingham
Goldstein, Herbert.........22100 Coolidge Hwy., Oak Park 37
Good, Wayne T.........3306 Auburn Rd., Auburn Heights
Goode, Norman J., Jr.........1117 S. Washington Ave., Royal Oak

Gordon, Clayton H.....1099 N. Cranbrook Rd., Birmingham
Gradolph, Paul L.........23338 Woodward Ave., Ferndale 20
Gray, Murray H.....................22100 Coolidge, Oak Park 37
Grayson, Joseph R................................156 Palmer St., Pontiac
Green, J. Donald.....................217 Briggs Bldg., Birmingham
Green, Ralph S......................24100 Stratford, Oak Park 37
Green, Willard M.................................35 S. Johnson, Pontiac
Grekin, Thos. D...........603 W. Eleven Mile Rd., Royal Oak
Gustafson, Everette.............................35 S. Johnson, Pontiac
Gutterman, Meyer A.....25085 Coolidge Hwy, Oak Park 37

Haanes, Merle A.......................909 Woodward Ave., Pontiac
Hackett, Danl. J. (L).......................782 Owego Dr., Pontiac
Hagman, George L. (L)................711 Rogue Valley Manor, Medford, Ore.
Hague, Gilbert W...........739 Westview Rd., Bloomfield Hills
Halsted, Lee H...........23023 Orchard Lake Rd., Farmington
Hambalgo, George J..............26800 W. 13 Mile Rd., Franklin
Hamburger, Joel I.............20905 Greenfield Rd., Southfield
Hamilton, Quentin P.................20905 Greenfield, Southfield
Hammonds, Everett E. (A)................7680 E. Northland Dr., Scottsdale, Arizona
Han, Maolin....................3358 Auburn Rd., Auburn Heights
Harmon, Lewis G.............1775 E. 14 Mile Rd., Birmingham
Harrold, John A.............................534 Franklin Rd., Pontiac
Harvey, Campbell (L)............35 W. Huron St., Pontiac 15
Hassberger, John B.....620 N. Woodward Ave., Birmingham
Hathaway, Wm. S...............................433½ Main, Rochester
Hayden, H. S., Ph.D. (A)..............Wm. Beaumont Hospital, Royal Oak
Henderson, H. R.................33750 Freedom Rd., Farmington
Henderson, James E.......765 Oakleigh Dr., Bloomfield Hills
Henderson, Worth W...........1307 S. Washington, Royal Oak
Hendren, Owen S.......1408 Pontiac Bank Bldg., Pontiac 14
Hendricks, Frank P...........21701 W. 11 Mile Rd., Southfield
Henry, Colonel R. (L)......125 W. Nine Mile Rd., Ferndale
Hensley, Chas. B.....................248 S. Broadway, Lake Orion
Herman, Edward L.....................429 Walnut Blvd., Rochester
Hermes, Charles R.............................. 5790 M 15, Clarkston
Heyboer, Donald J...............St. Joseph Mercy Hosp., Pontiac
Hoekman, Aben..............1740 Hamilton Dr., Rte. 3, Pontiac
Holt, Willard, Jr..........................Pontiac Gen. Hosp., Pontiac
Hopkins, Melvin, Jr.,..............900 Baldwin Ave., Pontiac 11
Hopkins, Wm. J...........17000 W. Eight Mile Rd., Southfield
Howell, Lynn E.........................909 Woodward Ave., Pontiac
Hrushka, Myroslaw..................Pontiac State Hosp., Pontiac
Hsu, John J...............................Pontiac State Hosp., Pontiac
Hubert, John R...................880 Woodward Ave., Pontiac 14

Ignatius, Aram A.........1915 E. Nine Mile Rd., Ferndale 20
Issac, Herbert L. (A)..........St. Joseph Mercy Hosp., Pontiac
Isgut, Roberto D.............29081 Dequindre, Madison Heights
Jacobi, Rodman C.........................91 S. Washington, Oxford
Jagnow, Nanette..................525 Southfield Rd., Birmingham
James, Robt. E., Jr...........2561 Elizabeth Lake Rd., Pontiac
Jenkins, Henry L...................................161 State St., Pontiac
Jennings, John A...............21701 W. 11 Mile Rd., Southfield
Johnson, Clare G.................909 S. Woodward Ave., Pontiac
Johnson, J. Frederic....23760 N. Woodward, Pleasant Ridge
Johnson, Robert H.........444 W. University Ave., Rochester
Jones, Cyril D..........................17128 Westmoreland, Detroit
Joyce, John A.......................413 Woodward Ave., Rochester
Jury, Donald B.............1126 S. Woodward Ave., Royal Oak
Kadian, George..................20905 Greenfield Rd., Southfield
Kamm, Robert L.................................625 Purdy, Birmingham
Katz, Austin M. (A)................Pontiac State Hosp., Pontiac
Katz, Sidney F...................................17350 Dorset, Southfield
Kaufman, Jacob M...............3340 Berkshire Dr., Birmingham
Kay, Sherman A.................1026 S. Washington, Royal Oak
Kazdan, Louis L.....13801 W. Nine Mile Rd., Oak Park 37
Keeffe, Eugene J.......................880 Woodward Ave., Pontiac
Keith, Kelly.....................................751 Chestnut, Birmingham
Kemp, Felix J.........................880 Woodward Ave., Pontiac
Kendrick, H. F., Jr.............................35 S. Johnson, Pontiac
Kennison, Warren S.......................250 Martin, Birmingham
Kerr, Edwin C.........................32749 Franklin Rd., Franklin
Ketchum, Jesse....26075 Woodward Ave., Huntington Woods
Kettler, Hans J.....................25160 Edgemont Rd., Southfield
Khodadadeh, B.........4252 Orchard Lake Rd., Orchard Lake
Kinsley, George.........................909 Woodward Ave., Pontiac
Klass, Arthur........................1026 S. Washington, Royal Oak
Klegman, Jerome H.....1700 W. Eight Mile Rd., Southfield
Klewicki, H. A.......................22720 Woodward, Ferndale 20
Knights, Edwin M.....................16001 9 Mile Rd., Southfield
Knox, Richard S.............325 Washington Sq. Pl., Royal Oak
Koehler, Wm. H.............4416 Far Hill Dr., Bloomfield Hills
Koltonow, Lawrence....304 Northland Med. Bldg., Southfield
Kompus, Larry L. (A)..............Pontiac Gen. Hosp., Pontiac
Kornmesser, James G....................23023 Orchard Lake Rd., Farmington
Kozlow, Clifford S...............4274 N. Woodward, Royal Oak
Kozlow, L. Ange.................4274 N. Woodward, Royal Oak
Kozonis, Michael C.................880 Woodward Ave., Pontiac
Kozora, Elmer J...............17650 W. 12 Mile Rd., Southfield
Krane, Mark.......................................125 Alice Ave., Pontiac
Kresge, Bruce A......................1500 Walton Blvd., Rochester
Krieger, Norman N...................................402 Union St., Milford
Krohn, Don R...........23023 Orchard Lake Rd., Farmington
Kuhel, Eli H........................20905 Greenfield Rd., Southfield
Kuhn, Anne C...................4203 W. 13 Mile Rd., Royal Oak
Kuhn, Robt. E.................4203 W. 13 Mile Rd., Royal Oak
Kurnetz, Ruben..............10831 W. Ten Mile Rd., Oak Park
Ladd, James E.........................31815 Southfield, Birmingham
Lahti, Paul T......................3600 W. 13 Mile Rd., Royal Oak
Lambert, Alvin G.................3027 N. Woodward, Royal Oak
Lambie, John S. (L)..................280 Aspen Rd., Birmingham
Landers, James W............................20402 Williamsburg Rd., Dearborn Heights
Landry, Roy A...................Clarkston Prof. Center, Clarkston
Larson, Alvin R.......................880 Woodward Ave., Pontiac
Laux, Philip J., Jr...............3027 N. Woodward, Royal Oak
Leach, Chas. A., Jr.............525 Southfield Rd., Birmingham
Leahy, Etta Link (R).........................1616 Wiltshire, Berkley
Leichtman, R. R...................5770 Ortonville Rd., Clarkston
Lessien, Bruce T.............4045 W. Thirteen Mile, Royal Oak
Levin, Murray B...............7046 Cathedral Dr., Birmingham
Levine, Bernard....25835 Parkwood Dr., Huntington Woods
Lewis, Sol M. (L).......................541 W. Oakridge, Ferndale
Lichtwardt, Harry E.......247 N. Hunter Blvd., Birmingham
Lichtwardt, John R.........247 N. Hunter Blvd., Birmingham
Lievois, Edward G...........289 Westbourne Dr., Birmingham
Lilly, Richard J.......................25336 Castlereigh, Farmington
Limia, Antonio G.....................24360 Kenosha, Oak Park 37
Ling, T. W.....................23607 Farmington Rd., Farmington
Linn, Herman J.................3601 W. 13 Mile Rd., Royal Oak
Longyear, Harold W.........4045 W. 13 Mile Rd., Royal Oak
Lowell, James W.........................2330 Fairway, Birmingham
Lowery, Anthony J. (R).............8030 Flagstaff, Union Lake
Lussos, A. S.......................2707 Bridle Rd., Bloomfield Hills
Lutes, Byron B.............1401 S. Washington Ave., Royal Oak
Lyons, Robt. T...................................35 S. Johnson, Pontiac

Manz, Howard N.......23023 Orchard Lake Rd., Farmington
Marcotte, Oliver J. (A)..25000 W. Ten Mile Rd., Southfield
Margrave, Edmund D. (L)................306 W. Ten Mile Rd., Royal Oak
Margulis, R. Ralph..................31815 Southfield, Birmingham
Markley, John M.................655 Ridge Rd., Bloomfield Hills
Maroko, Simon W.................Pontiac State Hospital, Pontiac
Marra, John J.......................................35 S. Johnson, Pontiac
Marsa, Percy S. (A)............Heri Mission Hosp., Po Kasulu, Tanganyika, East Africa
Martin, Donald W.....................Pontiac State Hosp., Pontiac
Martin, Francis A.............................880 Woodward, Pontiac
Mason, Robt. J.............618 N Woodward Ave., Birmingham
Mathura, G. R......................................606 Riker Bldg., Pontiac
Mayo, Barry W. E.........2338 N. Woodward Ave., Royal Oak
Mayor, Raymond L.............................35 S. Johnson, Pontiac
McCain, French H.......628 N. Woodward Ave., Birmingham
McCandliss, D. H...............................35 S. Johnson, Pontiac
McConkie, James P...............2425 W. Lincoln, Birmingham
McDonald, Robert J.....4200 N. Woodward Ave., Royal Oak
McElroy, Wm. J., Jr.............420 East Fourth St., Royal Oak
McEvoy, Francis J.....................1715 Crooks Rd., Royal Oak
McHugh, James M.............20905 Greenfield Rd., Southfield
McInerney, Thos. S........................2026 Laurome, Royal Oak
McIntyre, Jack B...............................625 Purdy, Birmingham
McIntyre, Kenneth E. (A)..........................3830 Maule Rd., Pensacola, Fla.
McLaughlin, J. H.................604 N. Woodward, Birmingham
McNeill, Howard H...........................225 W. Hickory Grove, Bloomfield Hills
McPhee, Edward C...........................909 Woodward, Pontiac
McWhirter, W. W...............................302 Walnut, Rochester

Megler, Mihael A..................3710 S. Darlington, Birmingham
Mehas, Constantine P.....1060 Trailwood Path, Birmingham
Mehrabian, Edw. E..........................30671 Stephenson Hwy., Madison Heights
Meils, Richard K. (A)..........Pontiac General Hosp., Pontiac
Meisner, Harry E.........25497 Hereford, Huntington Woods
Mercer, Frank A. (L)....................3032 Morningview Terr., Birmingham
Mevorah, Barukh L...................114 S. Lafayette, Royal Oak
Milgrom, Sidney............1229 S. Washington St., Royal Oak
Miller, Arthur C.................31723 Waltham Ct., Birmingham
Miller, Hazen L...............31815 Southfield Rd., Birmingham
Miller, Hubert..........................28554 Rivercrest, Southfield
Miller, Irving M.........23023 Orchard Lake Rd., Farmington
Miller, Sidney..............................800 S. Adams, Birmingham
Mimura, James T...................31815 Southfield, Birmingham
Moloney, James C........5851 Farmington Rd., Orchard Lake
Montgomery, J. C. (L)..............................26711 Woodward, Huntington Woods
Morin, Leonard A..................29929 Vernon Dr., Southfield
Mueller, Elmer J...............31815 Southfield Rd., Birmingham
Mumby, Clinton J..................................26789 Woodward Ave., Huntington Woods
Munson, Harry L.................MacKenzie Clinic, Walled Lake
Murguz, Atalay M.................1625 E. Fourth St., Royal Oak
Nalbandian, Robt. M.....5154 Nob Hill Ct., Bloomfield Hills
Nalepa, Eugene J.....................880 Woodward Ave., Pontiac
Nasizadeh, M. R. (A)...........................(Address Unknown)
Naz, John F. (A)..................2826 Orange Grove, Waterford
Nessel, Jack H......................................880 Woodward, Pontiac
Netzel, Robert J....................................1376 Eason St., Pontiac
Newby, Burns G.........................20905 Greenfield, Southfield
Newcomb, Arnold B.........19834 Riverside Dr., Birmingham
Nichamin, Samuel J...........20905 Greenfield Rd., Southfield
Nickerson, Ivey D...............6245 Golfview Dr., Birmingham
Niederluecke, D. C..............................35 S. Johnson, Pontiac
Nol, Edward A. (A)...................Pontiac State Hosp., Pontiac
Nosanchuk, Jos. I..................................35 S. Johnson, Pontiac
Nunn, James W.............................751 Chestnut, Birmingham
O'Donnell, C. H.............23338 Woodward Ave., Ferndale 20
Oliphant, Wm. W.................785 N. Lapeer Rd., Lake Orion
Olsen, Richard E.........................900 Woodward Ave., Pontiac
O'Neill, James A......................................5790 M 15, Clarkston
Ormond, John K. (L)..............909 Woodward Ave., Pontiac
O'Sullivan, Girardin S....................26520 Willowgreen Way, Franklin
Ott, Harold A........................3019 N. Woodward, Royal Oak
Overy, Donald C........................880 Woodward Ave., Pontiac
Packard, David C.........................5770 Highland Rd., Pontiac
Page, Oliver W., Jr......................................500 W. Huron, Pontiac
Palmer, Hayden D. (L)..................35 W. Huron St., Pontiac
Paragas, Pedro W. (A)..............Pontiac State Hosp., Pontiac
Paris, S. William........23023 Orchard Lake Rd., Farmington
Patel, Vishnubhai (A)................Pontiac Gen. Hosp., Pontiac
Patrick, Chas. I.................4721 Dixie Hwy., Drayton Plains
Patterson, J. C...............3600 W. Thirteen Mile, Royal Oak
Pauli, Theodore H. (A)..........880 Woodward Ave., Pontiac
Payton, Chas. F........................1719 Crooks Rd., Royal Oak
Pear, Erwin G...............3027 N. Woodward Ave., Royal Oak
Pearce, James F.............306 S. Washington Ave., Royal Oak
Peirce, Wm. H........................800 S. Adams Rd., Birmingham
Pelletier, Chas. J.....................1111 N. Campbell, Royal Oak
Pensavecchia, J. S.................................2680 Garland, Pontiac
Perry, Richard W...no address listed
Pfister, Richard C. (A)................................14 Utica, Pontiac
Pool, Robert, Jr......................800 S. Adams Rd., Birmingham
Porter, Kenneth F.............2709 Bradway Blvd., Birmingham
Portnoy, Harold D.......................445 W. Huron St., Pontiac
Ports, Preston W.................33108 Grand River, Farmington
Poznanski, Elva O..............................26789 Woodward Ave., Huntington Woods
Poznanski, W. A.........1100 N. Woodward Ave., Birmingham
Pridmore, John..........................2741 Onagon Trail, Pontiac
Proctor, Bruce..3431 Baldwin, Pontiac
Quarton, Albert E., Jr...........542 Pilgrim Rd., Birmingham
Quigley, J. Patrick (A)............3229 Belle Court, Royal Oak
Quinn, James R., Jr.....2070 W. Valley Rd., Bloomfield Hills
Ragins, Abner I...........................909 Woodward Ave., Pontiac
Ramirez, Joaquin J.......................751 Chestnut, Birmingham
Ranney, Kenneth I.............1100 N. Woodward, Birmingham
Raynale, George P. (L)......302 Wabeek Bldg., Birmingham
Read, James A.....................610 N. Woodward, Birmingham
Rech, Wm. R.......................MacKenzie Clinic, Walled Lake
Reid, Fred T...............................49 W. 14 Mile Rd., Clawson
Reid, Robert E..............................2958 Woodslee, Royal Oak
Reilly, Richard C.....................880 Woodward Ave., Pontiac
Rendziperis, N. C.......................118 W. Third St., Rochester
Reutter, Carolyn............17600 Northland Pk. Ct., Southfield
Richard, Robert E...................1719 Crooks Rd., Royal Oak
Richards, Wilson P...........3500 W. Maple Rd., Birmingham
Richardson, Robt. P.....26711 Woodward, Huntington Woods
Riggs, Harry L..........................149 Franklin Blvd., Pontiac
Riker, Aaron D. (L)........................640 Riker Bldg., Pontiac
Roehm, Harold R.................319 Wabeek Bldg., Birmingham
Romanik, John N...........31601 W. 13 Mile Rd., Farmington
Rossin, Herbert W...............20905 Greenfield Rd., Southfield
Roth, Herbert J.............31601 W. 13 Mile Rd., Farmington
Rowley, Laurie G. (L)......4400 Dixie Hwy., Drayton Plains
Ruesink, Donald E.............................127 Ferndale, Rochester
Rupp, Edson C., Jr.......1775 E. Fourteen Mile, Birmingham
Rush, Alva D., Jr.........................391 Hamilton, Birmingham
Ruskin, David S....................20905 Greenfield Rd., Southfield
Russell, Vincent P.......324 Washington Sq. Plaza, Royal Oak
Rutzky, Julius......................St. Joseph Mercy Hosp., Pontiac
Ruva, Jos. J.......................4463 Dixie Hwy., Drayton Plains
Sadovsky, Vincent J.................880 Woodward Ave., Pontiac
Safavian, M. H. (A)..........900 Woodward Ave., Pontiac 19
St. John, Harold A...............35 West Huron St., Pontiac 15
Salisbury, C. S.......................21580 Greenfield, Oak Park 37
Salva, Donald L....................................16179 Bentler, Detroit
Samborski, Anne H.............32316 Grand River, Farmington
Sanford, Glenn A.................................35 S. Johnson, Pontiac
Sansone, Thos. J......................909 Woodward Ave., Pontiac
Satersmoen, Theodore...............................35 S. Johnson, Pontiac
Schaefer, Wm. C..........................240 Daines St., Birmingham
Schirle, Jos. L., Jr......................1116 Voorheis Rd., Pontiac
Schlecte, I. Carl (A)....................P.O. Box 1187, Ann Arbor
Schmitt, Phillip E. (A)................ V. A. Hospital, Dearborn
Schneyer, Jerome J.......25000 W. Ten Mile Rd., Southfield
Schoenfeld, Robt. J.....794 N. Woodward Ave., Birmingham
Scholes, Danl. R..............................277 Pierce St., Birmingham
Schreiner, Robt. J. (A)..........16909 Dunblaine, Birmingham
Schuneman, Howard A.......................23760 Woodward Ave., Pleasant Ridge
Schwartz, David............33120 W. Twelve Mile, Farmington
Schweinsberg, Stephen....................1109 W. Long Lake Rd., Bloomfield Hills
Seaborn, Arthur J.......1413 S. Washington Ave., Royal Oak
Segula, Robt. L...................................35 S. Johnson, Pontiac
Selman, Robert..............................500 W. Huron St., Pontiac
Sempere, Chas. R..............................35 S. Johnson, Pontiac
Sewell, Geo. R.......411 West Ten Mile Rd., Pleasant Ridge
Shadley, Maxwell L..........................94 Ottawa Dr., Pontiac
Shea, James Joseph...............................35 S. Johnson, Pontiac
Sheffield, Loren C.................................35 S. Johnson, Pontiac
Sheridan, F. Michael......1307 S. Washington St., Royal Oak
Sherkat, Mehdi (A)......Wm. Beaumont Hospital, Royal Oak
Siegel, Marvin D..........................445 W. Huron St., Pontiac
Siffring, Loren W.....................427 W. University, Rochester
Silberg, Joel J...................................29742 Everett, Southfield
Silvani, John..............................909 Woodward Ave., Pontiac
Simpson, Edward K. (L)..............................2 Sunset Avenue, Chatham, Ont., Canada
Simpson, John R...........................800 S. Adams, Birmingham
Smith, Carleton A...................880 Woodward Ave., Pontiac
Smith, Donald S..............................936 Riker Bldg., Pontiac
Smith, Geo. E.............629 Washington Sq. Plaza, Royal Oak
Somerville, Wm. J.................145 Cambridge, Pleasant Ridge
Sosin, Allen....................23023 Farmington Rd., Farmington
Spademan, Loren C.............484 Warren Court, Birmingham
Spencer, Lloyd H.........1219 S. Washington Ave., Royal Oak
Spoehr, Eugene L...........22832 Woodward Ave., Ferndale 20
Spohn, Earle W.......................201 S. Center St., Royal Oak
Stageman, John C.............................909 Woodward, Pontiac
Stanisavljevic, S.................2338 Woodward Ave., Royal Oak
Stanley, Wm. F.....................1148 S. Woodward, Royal Oak
Steffes, Everette M....................3345 Coolidge Hwy., Berkley
Stolpman, A. K......................640 N. Woodward, Birmingham
Stone, John M. (A)..........Wm. Beaumont Hosp., Royal Oak
Stratton, Donald P. ....889 Second St., Muskegon
Stremler, Bernard J...............1460 Chesterfield, Birmingham
Stuecheli, Milton B...............1084 Willow Lane, Birmingham
Stulte, Jon L. (A)..................995 N. Cass Lake Rd., Pontiac
Sullivan, Paul M........................909 Woodward Ave., Pontiac

Sutton, Palmer E. (A)..........222 Linden, Birmingham
Swickle, Edward F..........17 S. Main, Clawson
Swingle, Norman E..........2075 E. 14 Mile Rd., Birmingham
Szappanyos, Bela..........3325 Burning Bush Rd., Birmingham
Szybko, Valentine..........4274 N. Woodward, Royal Oak

Tarpinian, Dick A..........24601 Coolidge Hwy., Oak Park
Tauber, Abraham..........500 W. Huron St., Pontiac
Teshima, John Y..........22720 Woodward Ave., Ferndale 20
Tierney, Thomas D..........450 N. Woodward, Birmingham
Torgerson, Thos. S.....794 N. Woodward Ave., Birmingham
Touma, Alfred....26789 Woodward Ave., Huntington Woods
Tregenza, Wm. K..........20905 Greenfield, Southfield
Trumpour, Donald J..........114 W. University Dr., Rochester
Tsiatalas, George..........3237 Belle Court, Royal Oak
Turner, Kirby L. (A)..........1445 Nokomis Dr., Lake Orion

Ulgenalp, Attila O..........880 Woodward Ave., Pontiac
Ulveling, Robert A..........500 W. Huron St., Pontiac
Urwiller, K. L..........909 Woodward Ave., Pontiac

Van De Leuv, John H..........91 S. Washington St., Oxford
Vanden Berg, Kenneth..........35 S. Johnson, Pontiac
Van Zoeren, Jay J..........937 Rock Spring Rd., Birmingham
Varbedian, Thos. G..........205 Wabeek Bldg., Birmingham
Vaught, Richard K..........2009 Crooks Rd., Royal Oak
Victoria, M. A. (A)..........108 Auburn, Pontiac
von Valtier, Cheryl C. (A)..........202 Walnut, Rochester
von Valtier, Wm. F..........202 Walnut, Rochester

Waehneldt, Niels R..........21730 Edna, Dearborn
Wagner, Ruth E. (L)..........315 Ellen Ave., Royal Oak
Wake, Douglas L..........1406 Woodsboro, Royal Oak
Wallace, Donald B..........880 Woodward Ave., Pontiac
Wallack, Erwin N..........15660 W. Ten Mile Rd., Southfield
Wangner, William F..........1401 S. Washington, Royal Oak
Ward, W. Paul..........6631 Castle Drive, Birmingham
Warner, Fredk. O..........3400 Sashabaw Rd., Drayton Plains
Watson, Robert M..........402 Union St., Milford
Watson, Thos. Y..........640 N. Woodward, Birmingham
Watts, Fredric..........Pontiac State Hosp., Pontiac
Weaver, Arthur (A)..........91 Depot Line, Karachi, West Pakistan
Weaver, Wm. F..........33750 Freedom Rd., Farmington
Webber, Lynn F. (R)..........461 Colonial Ct., Grosse Pte. 36
Wechsler, Norman..........880 Woodward Ave., Pontiac
Wegrzyn, George C..........1380 Brookwood, Birmingham
Weisman, Lawrence S..........909 East 12 Mile Rd., Madison Heights
Weiss, Morris......26339 Woodward Ave., Huntington Woods
Wendling, Dieter..........31815 Southfield Rd., Birmingham
Wessels, Robt. R..........302 Wabeek Bldg., Birmingham
Westfall, Edwin J..........1665 Twelve Mile Rd., Berkley
Westmaas, Wm. J..........364 Roanoke St., Birmingham
White, R. Hamilton..........384 Hamilton Ave., Birmingham
Wiant, John L..........258 Briggs Bldg., Birmingham
Wigent, Ralph D..........35 S. Johnson, Suite 26, Pontiac
Wilkinson, Wm. C..........880 Woodward Ave., Pontiac
Williams, John P..........35 S. Johnson, Pontiac
Willis, Maurice E..........35 S. Johnson, Pontiac
Wolfe, Warren E..........450 N. Woodward Ave., Birmingham
Woodward, Hanna L..........950 East Maple, Birmingham
Woodward, Robert D..........1100 N. Woodward Ave., Birmingham

Yesko, Veldora C..........26075 Woodward Ave., Huntington Woods
Ylvisaker, John R..........880 Woodward Ave., Pontiac
Young, Arthur R..........35 W. Huron St., Pontiac 15

Zimmerman, Walter J..........32340 Sylvan Lane, Birmingham
Zinterhofer, J. J., Jr..........27621 Santa Barbara Dr., Lathrup Village
Zografov, Nikolas S..........3648 Rockingham, Royal Oak
Zujko, Alphonse J..........606 Riker Bldg., Pontiac

OCEANA COUNTY MEDICAL SOCIETY (178)

Barker, V. D..........22 N. State St., Hart
Davis, Linford J..........22 N. State St., Hart
Hasty, Willis A..........405 State St., Shelby
Johnson, C. A..........Box 6, New Era
Mullen, Warren R..........Pentwater
Ratzlaff, Alvin J..........219 State St., Hart
Robinson, Wm. G. (A)..........Memorial Hospital, Fatehgarh, U. P., India
Vrbanac, John J..........22 N. State St., Hart
Wood, Merle G..........19 Courtland St., Hart

ONTONAGON COUNTY MEDICAL SOCIETY (182)

Archibald, Donald H..........Box 223, Ontonagon
Hogue, Harold B..........Ewen State Bank Bldg., Ewen
Lahti, Carl R..........Route 2, Ontonagon
Pierpont, John..........141 Maple, White Pine
Strong, James P..........608 Michigan, Ontonagon
Strong, Wm. F..........River St., Ontonagon

OTTAWA COUNTY MEDICAL SOCIETY (186)

Albers, Robt..........788 Columbia, Holland
Arendshorst, Wm..........121 W. 24 St., Holland
Balcer, Edwin A. (M)..........VA Hosp., Livermore, Calif.
Beernink, Ernest H..........408 Fulton St., Grand Haven
Bloemendaal, Dirk C..........351 N. Main St., Zeeland
Bloemendal, W. B..........224 Washington St., Grand Haven
Boersma, Vernon L..........121 W. 24 St., Holland
Bonzelaar, Alvin..........144 West 26th, Holland
Boone, Cornelius E. (L)..........22 E. Central Ave., Zeeland
Bulthuis, Jerry E..........Jamestown
Chamness, James K..........121 W. 24th St., Holland
Clark, Nelson H..........17 W. 10 St., Holland
Cook, Carl S..........121 W. 24th St., Holland
DeVries, Harold G..........30 E. 9th St., Holland
DeVries, Peter J..........214 Washington St., Grand Haven
DeWitt, Donald E..........390 Fairhill Dr., Holland
DeYoung, Fredk. W..........Spring Lake
Dood, Arnold R..........598 Central Ave., Holland
Dykstra, Jerome H..........313 North River Ave., Holland
Endean, Donald H..........121 West 24th St., Holland
Frieswyk, Melvin J..........241 E. Main St., Zeeland
Gesnick, Owen J..........492 Orchard Hill, Holland
Groat, Frank L..........631 Franklin St., Grand Haven
Hager, Ralph..........Hudsonville
Hamelink, Marinus H..........700 W. 26th St., Holland
Harms, Herman P..........17 W. 10th St., Holland
Harvey, Dennis..........512 Woodlawn St., Grand Haven
Heard, Wm. (R)..........504 Park St., Grand Haven
Helbling, Edw. J., Jr..........17 W. 10 St., Holland
Henderson, Jack A..........1310 Wisconsin Ave., Grand Haven
Hommerson, H. J..........3559 M40, Hamilton
Kearney, Jos. B..........121 W. 24 St., Holland
Kemme, Gerrit J..........Rte. 3, Zeeland
Kitchel, John H..........414 Franklin St., Grand Haven
Kitchel, Mary F. S..........414 Franklin St., Grand Haven
Kools, Wm. C..........194 W. 11th St., Holland
Korpi, Steven..........520 Ottawa Ave., Grand Haven
Kuipers, Siebe W..........93 E. 29th, Holland
Leppink, Richard A..........121 W. 24th St., Holland
Mahaney, Robert C..........65 W. 22nd St., Holland
McArthur, Peter A..........414 Franklin, Grand Haven
Moerdyk, Wm. J..........120 W. 14th St., Holland
Nykamp, Russel R..........111 E. Main St., Zeeland
Post, J. Jay..........Allendale
Rottschaefer, Wm..........17 W. 10th St., Holland

Rotz, Lloyd..........575 Robbins Rd., Grand Haven
Rypkema, Willard M..........22 S. 2nd St., Grand Haven
Schaftenaar, R. H..........86 E. 28th St., Holland
Smit, George J..........121 W. 24th St., Holland
Smit, Henry (A)......c/o Dr. George Smit, 121 W. 24th St., Holland
Stobbelaar, Robt. H..........1310 Wisconsin, Grand Haven
Ten Have, Ralph..........1030 Orchard, Grand Haven
Ten Pas, Henry W..........293 W. 29th St., Holland
Timmerman, Eugene C..........Coopersville
Van Appledorn, C. J..........99 W. 23rd St., Holland
Vander Berg, Edwin E..........17 W. 10th St., Holland
Van Der Velde, Otto..........33 W. 8th St., Holland
Vande Waa, Alfred J..........152 E. Cherry St., Zeeland
Van Kolken, P. J..........American Hospital, Pago Pago, Amer. Samoa
Veenstra, Bernard M..........Grand Haven
Ver Duin, John W..........223 Washington St., Grand Haven
Verkaik, Peter..........Hudsonville
Wang, Charles..........14 E. 25th St., Holland
Wassink, Jerome H..........34 East 33rd, Holland
Wells, Kenneth N..........119 W. Savidge, Spring Lake
Westrate, Warren K..........17 W. 10th St., Holland
Westrate, Wm., Jr..........17 W. 10th St., Holland
Westrate, Wm., Sr. (L)..........17 W. 10th St., Holland
Winter, John K..........726 State St., Holland
Winter, Wm. G., Jr..........630 State St., Holland
Yff, John H..........430 W. Lawrence, Zeeland
Yonkman, Fredk. F..........58 Pomeroy Rd., Madison, N. J.

SAGINAW COUNTY MEDICAL SOCIETY (190)

Ackerman, Gerald L..........124 S. Jefferson Ave., Saginaw
Albers, Millard J..........1227 N. Michigan Ave., Saginaw
Anderson, Wm. K..........845 St. Andrews Rd., Saginaw
App, Robt. G..........3422 Davenport, Saginaw
Averill, Walter C..........2110 Morson, Saginaw
Bagley, Ulysses S. (R)..........1401½ N. Sixth St., Saginaw
Balcueua, Edgar P..........2 Chippewa Ct., Saginaw
Barry, Jack L..........5670 Dixie Hwy, Saginaw
Barry, Leroy C..........1600 N. Michigan Ave., Saginaw
Bass, Vernon V..........3322 Davenport, Saginaw
Behme, C. Peter..........5160 Helga Dr., Saginaw
Bellinger, Don H., D.D.S. (A)....215 Garden Lane, Saginaw
Bertrand, Marc G..........1311 N. Michigan Ave., Saginaw
Bishop, Harry M..........705 Adams, Saginaw
Bow, William A..........4987 State St., Saginaw
Brender, Friedrich P..........Frankenmuth
Bruggers, Laurence..........1703 N. Michigan Ave., Saginaw
Buechle, George J..........101 Marcy, St. Charles
Bullington, Bert M..........2000 Court St., Saginaw
Burnett, Quinter M..........4385 Concord, Saginaw
Busch, Frank J..........1731 N. Michigan St., Saginaw
Butler, Milton G..........1600 N. Michigan Ave., Saginaw
Cady, Donald J..........2002 Court St., Saginaw
Cady, Fredk. J., Jr..........402 S. Jefferson Ave., Saginaw
Cady, Fredk. J. (L)..........402 S. Jefferson Ave., Saginaw
Cambridge, V. W..........Potter at Jefferson, Saginaw
Cameron, Allan K..........1314 S. Jefferson Ave., Saginaw
Campbell, Lloyd A. (R)..........335 Brockway Pl., Saginaw
Caumartin, Hugh T.......1537 S. Washington Ave., Saginaw
Chisena, Peter R..........6221 Dixie, Bridgeport
Choate, Frances S..........1600 N. Michigan, Saginaw
Claytor, Archer A. (L)..........603 N. 3rd Ave., Saginaw
Cortopassi, Andre J..........326 S. Washingotn Ave., Saginaw
Cortopassi, Vital E..........324 S. Washington Ave., Saginaw
Cory, Chas. W..........1227 N. Michigan, Saginaw
Cresswell, T. A..........1236 N. Michigan, Saginaw
Cullen, Geo. (A)..........2529 N. Clinton St., Saginaw
Curts, James H..........1205 N. Michigan Ave., Saginaw
Davenport, Clyde P..........2110 Morson, Saginaw
Derifield, R. S. (A)..........25 Bretton Ct., Saginaw
DeYoung, William A..........537 Millard St., Saginaw
Dowidat, Raymond W. (A)..........608 Westfield, Saginaw
Durman, Donald C..........1600 N. Michigan Ave., Saginaw
Ely, Cecil W..........1820 James Ave., Saginaw
Ernst, Arthur R. (R)..........Fieldmont, The Plains, Va.
Farley, Albert W..........1013 N. Michigan Ave., Saginaw
Feeheley, Robert D..........3521 State St., Saginaw
Field, E. Malcolm..........1013 N. Michigan Ave., Saginaw
Fleschner, Thos. E..........Birch Run
Forster, Kenneth J..........27 Benton Rd., Saginaw
Galsterer, Edwin C..........128 S. Jefferson Ave., Saginaw
Gamon, Adam E., II..........2004 Court St., Saginaw
Gardner, Joe H..........815 N. Michigan Ave., Saginaw
Gerard, Roy J..........2419 Mackinaw, Saginaw
Gilmore, Robt. D..........234 W. Saginaw, Merrill
Goldner, Richard D..........1024 N. Michigan, Saginaw
Gomon, Louis D..........1203 N. Michigan Ave., Saginaw
Goodsell, John O..........1600 N. Michigan, Saginaw
Goodsell, J. Orton, D.D.S. (A)......1607 Cedar St., Saginaw
Goodwin, J. E..........515 S. Jefferson, Saginaw
Hand, Eugene A..........126 N. Franklin St., Saginaw
Harris, Geo. P..........1311 N. Michigan Ave., Saginaw
Harvie, Lloyd C. (L)......330 S. Washington Ave., Saginaw
Heavenrich, Robt. M..........1107 Gratiot Ave., Saginaw
Heilbronn, Duane B..........1703 N. Michigan, Saginaw
Heinmiller, E. C..........Saginaw Gen. Hosp., Saginaw
Helmkamp, Herbert O..........333 S. Jefferson, Saginaw
Hereza, Valeriano D..........2125 Bay St., Saginaw
Hester, Eustace G..........2031 N. Michigan Ave., Saginaw
Hill, Victor L., Jr..........1703 N. Michigan Ave., Saginaw
Hines, Ronald G..........St. Marys Hosp., Saginaw
Hoban, Sean J..........1232 N. Michigan Ave., Saginaw
Hubinger, H. L., D.D.S. (A)......501 2nd Natl. Bank Bldg., Saginaw
Hyslop, Wm. T..........1610 Gratiot Ave., Saginaw
Iizuka, Reiichi..........49 Davis Dr., Saginaw
Infante, A..........1931 E. Genesee, Saginaw
James, John W..........1021 W. Genesee St., Saginaw
Jardinico, Robert..........303 S. Grange, Saginaw
Jarvi, Rudolph M..........1107 Gratiot Ave., Saginaw
Johnson, G. T. (A)..........VA Hospital, Saginaw
Johnstone, Kermit T..........1050 Fisher Dr., Saginaw
Jordan, Leo A..........1524 E. Genesee St., Saginaw
Kerr, Wm. B..........300 S. Michigan St., Saginaw
Keyes, James T..........10222 Maple Rd., Birch Run
Kickham, Edward F..........705 Adams St., Saginaw
Kleekamp, Herbert G..........1005 Gratiot Ave., Saginaw
Kleinschmidt, Earl E..........3625 Webber St., Saginaw
Kolesar, Robt. C..........1005 Gratiot, Saginaw
Koucky, Charles J..........1375 Coolidge, Saginaw
Kowals, Francis V.....Med. Dir., Chec. Ser., GMC, Saginaw
Kretschmer, Thos. V. (A)..1232 N. Michigan Ave., Saginaw
Lassignal, Jules C..........1600 N. Michigan Ave., Saginaw
Ling, Kenneth C..........Hemlock
Lohr, Oliver W. (L)..........614 Madison, Saginaw
Lohr, Thos. O..........1135 N. Michigan Ave., Saginaw
Love, Neil W..........505 W. Tuscola, Frankenmuth
Lurie, Robt. I..........2525 S. Washington Ave., Saginaw
Mahaney, Thos. P..........3521 State St., Saginaw
Manning, John E..........815 N. Michigan Ave., Saginaw
Manning, John W., III..........705 Adams, Saginaw
Markey, Francis L..........808 N. Michigan Ave., Saginaw
Markey, Jos. P..........808 N. Michigan Ave., Saginaw
Martzowka, Wm. P..........415 W. Genesee St., Saginaw
Mason, Wm. G..........1107 Gratiot Ave., Saginaw
Matthews, Harry C..........1227 N. Michigan Ave., Saginaw
Maurer, John..........1109 Elmdale, Saginaw
Mayne, Harold E..........2111 Marshall Ct., Saginaw
McEwen, Wm. G..........1502 Court St., Saginaw
Meyer, Henry J. (L)..........6243 Dixie Hwy., Bridgeport
Mikan, V. Robert..........3900 Holland Dr., Saginaw
Miller, Glenn F..........2224 Mershon, Saginaw
Moon, A. Raymond (L)..........1008 Hancock, Saginaw
Mooney, James C..........1600 N. Michigan Ave., Saginaw
Morgrette, Leonard J..........3424 Davenport, Saginaw
Mudd, Richard D..........1629 N. Washington Ave., Saginaw
Mulhern, Donal T..........2716 S. Jefferson Ave., Saginaw
Murphy, Albert P..........303 N. Michigan Ave., Saginaw
Murphy, Richard T., D.D.S. (A)..........1718 N. Michigan, Saginaw
Murray, Morris J..........3424 Davenport, Saginaw

Nelson, Oscar A. .... 3324 Davenport, Saginaw
Nelson, Robert E. (A) .... 1500 Weiss St., Saginaw
Noble, Paul R. .... 1447 N. Harrison, Saginaw
Northway, Robt. O. .... 124 S. Jefferson Ave., Saginaw
Novy, Frank O. (L) .... 420 S. Jefferson Ave., Saginaw
Onderak, Edward P. .... No address
Phillips, Homer A. .... 124 S. Jefferson Ave., Saginaw
Pietz, Fredk. (L) .... 221 N. Michigan Ave., Saginaw
Powers, Robt. F. .... 1600 N. Michigan, Saginaw
Prather, Perry E. .... 1227 N. Michigan Ave., Saginaw
Prinsell, Gustave G. (M) .... P.O. Box 33, Sierra Leone, W. Africa
Rank, J. Eugene .... 1107 Gratiot Ave., Saginaw
Reichman, Jos. J. .... 1455 Sheffield, Saginaw
Reimers, Gerald F. .... 4046 Hess St., Saginaw
Rice, William T. .... 1827 N. Michigan Ave., Saginaw
Richards, Ned W. .... 3518 State St., Saginaw
Richter, Harry J. .... 705 Adams St., Saginaw
Roggen, Ivan J. .... 1227 N. Michigan, Saginaw
Ruskin, Dave B. .... 1600 N. Michigan Ave., Saginaw
Ryan, Richard S. .... 1315 S. Washington Ave., Saginaw
Sample, John T. (L) .... 602 Rust St., Saginaw
Sargent, Donald V. .... 1703 N. Michigan Ave., Saginaw
Schneider, A. J. N. .... 509 S. Jefferson Ave., Saginaw
Schultz, Frank R. .... 147 W. Broad St., Chesaning
Sharp, Martin C. .... 1803 N. Michigan Ave., Saginaw
Shek, John L. .... 803 N. Michigan Ave., Saginaw
Sheldon, Suel A. .... 124 S. Jefferson, Saginaw
Sherman, John W. .... 403 S. Fayette, Saginaw
Skowronski, C. A. .... 1401 E. Genesee St., Saginaw
Slade, Homer G. .... 1520 N. Michigan Ave., Saginaw
Speer, David L. .... 451 Westchester, Saginaw
Spengler, Donald E., D.D.S. (A) .... 4481 Bradford Dr., Saginaw
Stander, Aaron C. .... 1411 Court St., Saginaw
Stewart, Geo. W. .... 1902 Janes St., Saginaw
Sulfridge, Hugh L., Jr. .... 1011 N. Michigan Ave., Saginaw
Thompson, Arthur B. .... 2144 Ottawa St., Saginaw
Tiedke, Gunther E. .... 120 N. Michigan Ave., Saginaw
Toshach, Clarence E. (L) .... 3655 Schust Rd., Saginaw
Toteff, Robert J. .... 2110 Morson, Saginaw
Tramitz, Melvin E. .... 711 Somerset Rd., Saginaw
Tuttle, Terence K. .... 1109 Court St., Saginaw
Underhill, Wm. G. .... 8 Five Oaks, Saginaw
Vincent, John H. .... 1911 Seminole Lane, Saginaw
Vitu, Robert L. .... 703 W. Genesee, Saginaw
Volk, Vladimir K. .... Saginaw Co. Hosp., Box 65, Saginaw
Waite, Barry F. .... 403 S. Fayette, Saginaw
Webb, Walter L. .... 1502 Wadsworth, Saginaw
Weiss, Arno W. .... 3521 State St., Saginaw
Westlund, Norman .... 3253 Congress, Saginaw
Woomer, Donald F. .... 1227 N. Michigan Ave., Saginaw
Wright, Edwin M. .... 1311 N. Michigan, Saginaw
Yntema, Stuart .... 331 S. Jefferson Ave., Saginaw
Young, John .... 705 Cooper St., Saginaw

ST. CLAIR COUNTY MEDICAL SOCIETY (194)

Bailey, Robt. S. .... 2425 Military St., Port Huron
Banting, Kenneth C. .... 403 Peoples Bank Bldg., Port Huron
Barss, J. A. .... 1209 Tenth St., Port Huron
Battley, John C. S. .... 1216 6th St., Port Huron
Beck, Frank K. .... 2902 Military, Port Huron
Beer, Jos F. .... 104 N. Riverside Ave., Saint Clair
Bennett, Wm. G. .... 210 S. Main St., Yale
Blatter, Edwin W. .... 3864 Gratiot Ave., Port Huron
Borden, Chas. L. .... 236 Huron, Port Huron
Bottomley, Thos. H., Jr. .... 1102 Sixth St., Port Huron
Boughner, Walter H. .... 325 Pleasant St., Algonac
Bovee, Marion E. (L) .... 2208 Stone St., Port Huron
Bowden, Wm. S. .... 130 Washington, Marine City
Bridge, Ezra V. .... 416 Edison Blvd., Port Huron
Brush, Howard O. (L) .... 3233 Elk, Port Huron
Burke, Colman J. .... 411 Andrew Murphy Dr., Port Huron
Cantwell, John D., Jr. .... 2425 Military, Port Huron
Carrie, Robt. G. (A) .... 837 Marconi, Montebello, Calif.
Chafty, Mahmoud .... 2425 Military, Port Huron
Cleland, Wm. D., Jr. .... Medical Arts Bldg., Port Huron
Clifford, Robt. P. .... 506 S. Riverside Dr., St. Clair
Clyne, Benj. C. .... 103 N. Main St., Yale
Coury, John J., Jr. .... 1209 Tenth St., Port Huron
Davison, Wm. T. .... 2425 Military St., Port Huron
Dinnen, Wm. J., Jr. .... 2425 Military, Port Huron
Douvas, Nicholas G. .... 311 Pine St., Port Huron
Dupuis, Jean Paul .... 1502 Shumaker, Port Huron
Escalera, Gustavo .... 1605 Fred Moore Hwy., St. Clair
Fitzgerald, E. W., Jr. .... 1102 Sixth St., Port Huron
Franke, Armin T. .... 2425 Military, Port Huron
Fulton, Harold E., Jr. .... 2425 Military St., Port Huron
Gerrits, James F. .... St. Clair Clinic, St. Clair
Gholz, Anthony C. .... Medical Arts Bldg., Port Huron
Gilmore, John R. .... 317 Mich. Bank Bldg., Port Huron
Gonzalez, Carlos F. .... 1605 Division Rd., St. Clair
Hazledine, H. J. .... 4685 Lakeshore Rd., Port Huron
Holcomb, Russell J. .... 140 S. Market, Marine City
Johnston, Thomas C. .... 2425 Military St., Port Huron
Kahn, Oscar B. .... Capac
Kirban, Harry N. .... 5500 Lakeshore Rd., Port Huron
Koch, Donald A. .... 2425 Military St., Port Huron
Kostoff, Harold R. .... 310 Water St., Port Huron
Lauridsen, James .... 621 River St., Port Huron
LeGalley, K. B. .... Awali, Bahrain, Persian Gulf
Licker, Reuben R. .... 2425 Military St., Port Huron
Ludwig, Claude A. .... 916 Seventh St., Port Huron
Ludwig, Fredk. E. .... 916 7th St., Port Huron
Lugg, Robt. M. .... 619 River St., Port Huron
Mayhew, Harry E. .... 8199 S. Riverside, Marine City
McColl, Duncan J. (L) .... 917 Prospect Place, Port Huron
McCormick, Harry .... Port Huron Gen. Hosp., Port Huron
Meza, Pedro .... 902 Tenth, Port Huron
Miller, John M. .... 1010 Griswold St., Port Huron
Mohney, Glenn E. .... 311 Pine St., Port Huron
Morris, Alvin N. .... 621 River St., Port Huron
Neruda, Fred .... Algonac
Novak, Walter S. .... 310 E. Water St., Port Huron
Patterson, Dorsey W. (L) .... 622 Huron Ave., Port Huron
Pollock, Donald A. (A) .... 5014 Lakeshore, Port Huron
Raftery, Michael .... 2425 Military, Port Huron
Rowe, Robt. E. .... 108 McMorran Blvd., Port Huron
Sanderson, Jos. L. .... 515 Pine St., Port Huron
Sands, Geo. E. (L) .... 3227 Gratiot Ave., Port Huron
Schaefer, Waldo A. .... 302 Mich. Bank Bldg., Port Huron
Selby, Clarence D. .... 1916 Military St., Port Huron
Serniak, John A. .... 104 S. Main St., Yale
Shoudy, Elmore D. .... 902 Tenth Ave., Port Huron
Sites, Edgar C. .... 1209 Tenth St., Port Huron
Snider, James J. .... 2425 Military, Port Huron
Tisdel, James H. .... 310 E. Water St., Port Huron
Tomsu, Glenn F. .... 310 E. Water St., Port Huron
Townley, Chas. O. .... 1209 Tenth St., Port Huron
Ulmer, Arthur H., Jr. .... 1209 Tenth St., Port Huron
Walker, Sidney C. .... 1209 Tenth St., Port Huron
Ware, J. Raleigh .... 3107 24th St., Port Huron
Wass, Henry C. .... 115 Adams, St. Clair
Weckesser, W. C. .... 1602 Military, Port Huron
Yost, Kenneth W. .... 1305 Gratiot Ave., Marysville
Youngs, John A. .... 718 Griswold St., Port Huron
Yull, Arthur B. .... 1209 Tenth St., Port Huron

ST. JOSEPH COUNTY MEDICAL SOCIETY (198)

Berg, Lawrence A. .... 106 E. Chicago Rd., Sturgis
Bradley, D. E. .... 234 S. Main St., Colon
Braham, Wilbur G. .... 111 S. Monroe, Sturgis
Brothers, Paul L. .... 104 S. Lakeview, Sturgis
Brunson, Allen E. .... 206 E. West St., Sturgis
Dettman, Harold .... Maplecrest Plaza, Sturgis
Evans, Robt. H. .... 111 S. Monroe St., Sturgis
Fiegel, S. Albert .... 111 S. Monroe, Sturgis

Fortner, Roscoe J..................137 Portage Ave., Three Rivers
Gillespie, Eleanor M..R. 2, Sturgis
Hill, Robert V..........................117 Spring St., Three Rivers
Jacobowitz, John M..........Lincoln at Millard, Three Rivers
Lepard, Olin L..........................Knollwood Dr., R. 1, Sturgis
Miller, Chas. G. (L)................106 W. Chicago St., Sturgis
O'Dell, Charles W.................117 Spring St., Three Rivers
Olney, Frank (L)..Centerville
Pennington, Harry C..........118 S. Kalamazoo, White Pigeon
Penzotti, Stanley C....................117 Spring St., Three Rivers
Porter, Clark G..........................226 East St., Three Rivers
Schimnoski, D. R..........................Three Rivers Med. Clnc., Three Rivers
Shaw, Geo. D..........................117 Spring St., Three Rivers
Sheldon, John P..............................206 E. West St., Sturgis
Smith, Robt. D...Colon
Springer, Russell A. (R)....................................R. 2, Sturgis
Storer, William R..........................St. Jos. Co. Health Dept., Centerville
Weisheit, H. R..Route 1, Sturgis
Zimont, Chas. R..Constantine
Zimont, Raymond D..Constantine

SANILAC COUNTY MEDICAL SOCIETY (202)

Cripps, James R...Marlette
Ford, Frances A. (L).........2683 S. Lakeshore Rd., Applegate
Gift, Weldon A. (L)...Marlette
Groat, Gerald...Deckerville
Hart, Robt. K...Croswell
Jayson, Michael H......................2764 Lorraine St., Marlette
Magee, M. Catherine......11730 Saginaw Rd., Grand Blanc
McCrea, John W...Marlette
McGunegle, Keate T...Sandusky
Muir, Neil..Croswell
Seager, M. Cole..Brown City
Smith, Duane E..Brown City
Tweedie, G. Evans...Sandusky
Tweedie, S. Martin..Sandusky
Webster, J. C. (L)...Marlette
Winfield, Raymond J.....................3014 Main St., Marlette

SHIAWASSEE COUNTY MEDICAL SOCIETY (206)

Arnold, Alfred L., Jr. (L).......................................R. 1, Ovid
Austin, Eugene S...................................1260 Ada St., Owosso
Bach, Norman F.....................................113 E. Williams, Owosso
Bjarnesen, Walter.................Durand Medical Clinic, Durand
Brown, Richard C.....................113 E. Williams St., Owosso
Brown, Richard J. (R)................P.O. Box 1362, Ann Arbor
Buzzard, Walter D...Chesaning
Chipman, Elwood M. (R).........502 W. Williams St., Owosso
Clifford, Robert..Matthews Bldg., Owosso
Foerster, Alfred W.................113 E. Williams St., Owosso
Ford, Wm. J. A., Jr.................113 E. Williams St., Owosso
Forsyth, Henry T.....................137 S. Saginaw St., Chesaning
Graves, James H.......................................511 W. Main St., Owosso
Gurden, Elizabeth A. L.............113 E. Williams St., Owosso
Harroun, John E.........................105 N. Water St., Owosso
Harroun, R. V..224 N. Ball, Owosso
Hofstra, John ....Owosso
Hoshal, Verne L.............................104 W. Clinton, Durand
Kennedy, John J.........................1626 N. Chipman, Owosso
Lieber, Robt. W...................................6144 Pebbleshire, Flint
MacGregor, John F.................113 E. Williams St., Owosso
McGeehan, J. S....................................Mathews Bldg., Owosso
McKnight, Edwin R.............320 N. Washinton St., Owosso
Merz, Walter L..307 N Ball, Owosso
Moore Phillip J..............................221 E. North St., Owosso
Morin, Richard..Durand
Park, James H..................................812 Bradley St., Owosso
Phillips, Rolland.............................Matthews Bldg., Owosso
Richards, Chester J...............................213 Mercer, Durand
Roty, Robert L...Mathews Bldg., Owosso
Sahlmark, Jos. F..............................812 Bradley St., Owosso
Sauer, Peter......................................113 E. Williams, Owosso
Shepherd, Walter F. (R).........921 Coolidge Rd., Lansing 12
Trick, O. L. (A)................Duke University, Durham, N. C.
Weinkauf, Wm. F..Corunna
Weston, Claude L..........................Matthews Bldg., Owosso
Wickstrom, Geo. B.............................529 Clark Ave., Owosso

TUSCOLA COUNTY MEDICAL SOCIETY (210)

Anderson, Norma ....206 Ellington, Caro
Ballard, James H...Cass City
Chapin, Maurice H...Millington
Cole, Versa V...Lock Box A, Caro
Dickerson, Willard W.....................Caro State Hosp., Caro
Donahoe, Harold T.................................4674 Hill St., Cass City
Elmendorf, E. N., II...Vassar
Flett, Richard O...Millington
Gugino, George J.................................1941 Gate St., Reese
Howlett, Robt. R.............................624 W. Frank St., Caro
Kovacs, Geza...861 Gilford Rd., Caro
Merrill, Elmer H.......................................506 Gilfad Rd., Caro
Miles, Edward J...Caro
Nigg, Herbert L..Caro
Savage, Lloyd L. (L)............5208 Port Austin Rd., Caseville
Swanson, Ewald C......................................220 N. Main, Vassar
Von Renner, Otto (L)................837 W. Huron St., Vassar

VAN BUREN COUNTY MEDICAL SOCIETY (214)

Boothby, Carl F..Hartford
Boothby, Paul..Lawrence
Bope, Wm. P. (L)...Decatur
Cooper, Jos. E..............................417 W. Monroe St., Bangor
Davis, James M..........................424 Huron St., South Haven
Diephuis, Bert.........................511 Huron St., South Haven
Dillon, Thos. J...................................305 Oak St., Paw Paw
Gano, Avison.......................................417 Monroe St., Bangor
Genstler, Paul..................................Med. Dental Bldg., Gobles
Groustra, Glenn R.................511 Huron St., South Haven
Itzen, John F.............................P.O. Box 128, South Haven
Johnson, Harold C. A..................Upjohn Co., 320 Portage, Kalamazoo
Kleber, John A.............................365 Broadway, South Haven
Lawther, John...................................P.O. Box 191, Hartford
Loomis, Frank J..Paw Paw
McManus, T. M....................................Center Bldg., Paw Paw
Millard, David...Paw Paw
Morgan, Dale K.................403 Phoenix St., South Haven
Parks, Arthur E...Lawton
Spalding, R. W....................................Box 187, Bloomingdale
Stagg, Adelbert L...........................9 N. Maple St., Hartford
Stagg, G. Lee..Box 307, Hartford
Stagg, Ruth E. A...Box 38, Hartford
Steele, Arthur H...Paw Paw
Sundin, Paul W...Decatur
Ten Houten, Charles...Paw Paw
Terwilliger, Edwin H.................P.O. Box 110, South Haven
Urist, Martin J...R.D. 1, South Haven
Young, Wm. R. (L)..Lawton

WASHTENAW COUNTY MEDICAL SOCIETY (218)

Alford, Barry H..................................385 N. Mill, Plymouth
Allen, Arthur W..........................5 Harvard Pl., Ann Arbor
Allen, Richard J..................University Hospital, Ann Arbor
Anderson, David G......................627 Westwood, Ann Arbor
Atchison, Russell M.....................501 W. Dunlap, Northville

Badgley, Carl E. (L)............1313 E. Ann St., Ann Arbor
Bailey, Robt. W.....................University Hosp., Ann Arbor
Baird, Walter M................2558 Old Boston Ct., Ann Arbor
Bandera, Emily A.......................P.O. Box 1047, Ann Arbor
Bandera, Jaroslav M...4200 E. Huron River Rd., Ann Arbor
Banghart, Norman L.........................1950 Manchester Rd., Ann Arbor
Barker, Paul S. (R)....................Box 87, Bonnots Mill, Mo.
Barlow, R. Craig................326 N. Ingalls St., Ann Arbor
Barnwell, John B. (R)................R.F.D. 2, Blairstown, N. J.
Barron, Walter L........................326 N. Ingalls, Ann Arbor
Barry, Alexander, Ph.D. (A)........Med. Sc. Bldg., U. of M., Ann Arbor
Barss, Wm. A.............................525 W. Cross St., Ypsilanti
Bartholomew, Lee E.....................4633 Kresge Bldg., U.M., Ann Arbor
Bass, Thos. J.................................201 S. Hamilton, Ypsilanti
Bassow, Paul H.....................St. Joseph Hosp., Ann Arbor
Bauer, Gerhard H.............2015 Manchester Rd., Ann Arbor
Bauer, Jere M.........................1313 E. Ann St., Ann Arbor
Beckett, Morley B.................207 Fletcher Ave., Ann Arbor
Behrman, Saml.........................1313 E. Ann St., Ann Arbor
Beierwaltes, Wm. H.........................U.M. Medical Center, Ann Arbor
Beison, Richard A.........................1900 W. Stadium Blvd., Ann Arbor
Beljan, John R. (M).........................866 S. Vallombrosa Dr., Pasadena, Calif.
Bell, Margaret (L)........1107 E. Adelaide Dr., Tucson, Ariz.
Belser, Walter................2310 E. Stadium Blvd., Ann Arbor
Bender, Leonard F.....................1313 E. Ann St., Ann Arbor
Benson, Paul J., Jr.........................221 N. Sheldon, Plymouth
Benson, Ronald M. (A)......1053 Island Dr. Ct., Ann Arbor
Bentley, Fredk. E.........................851 S. Main St., Plymouth
Berkley, Kelly M.......810 E. Gravers Lane, Philadelphia, Pa.
Bicknell, John N.............703 First Natl. Bldg., Ann Arbor
Bishop, Ronald C.................1011 Lincoln Ave., Ann Arbor
Boblitt, Delbert E.........................St. Joseph Mercy Hosp., Ann Arbor
Boles, Roger...................................4785 Lake Ct., Ann Arbor
Borocz, Istvan (A)........St. Joseph Mercy Hosp., Ann Arbor
Bosch, Jan K..............................302 W. Main St., Northville
Botch, Edmund S.........2310 E. Stadium Blvd., Ann Arbor
Botsford, James H.........................109 N. Main St., Chelsea
Bourne, Charles W. (A)...............................Univ Hospital, Ann Arbor
Bradfield, R. John (A)..............1760 Traver Rd., Ann Arbor
Brandt, Ralph L.........................326 N Ingalls, Ann Arbor
Breakey, Barry A.........................2216 Medford, Ann Arbor
Brewer, Wilson K.............720 E. Catherine St.. Ann Arbor
Briere, Russell O. (A).......................2816 Brandywine Dr., Ann Arbor
Britt, Eugene M., Ph.D. (A)................1411 Bardstown Tr., Ann Arbor
Brody, Gerald L.........................1207 Chapel Ct., Ann Arbor
Brown, Philip N..No address
Brown, Wm. E., III................2101 Belmont Rd., Ann Arbor
Bryan, George C..............................2547 Ellis Rd., Ypsilanti
Bryant, H. C...........................425 E. Washington, Ann Arbor
Bucalo, Harry D., Jr.....................2207 S. Seventh, Ann Arbor
Buchanan, Robert A.................2715 Brockman, Ann Arbor
Bull, Frances E....................University Hospital, Ann Arbor
Burke, Dennis R..............................2991 Brassau Rd., Saline
Burton, Wm. D. (A)........University Med. Ctr., Ann Arbor
Bush, Jack L.....................1950 Manchester Rd., Ann Arbor
Butler, Gerald E.................................5 Dover Ct., Ann Arbor

Cameron, Geo. H..........................750 Dartmoor, Ann Arbor
Cameron, Hugh A.............425 E. Washington St., Ann Arbor
Campbell, Darrell A.....................617 Stratford, Ann Arbor
Carbeck, Robt. B.............................3080 Exmoor, Ann Arbor
Carek, Donald J..............................2787 Manchester, Ann Arbor
Carr, Edward A., Jr..................Dept. of Pharm. U. of M., Ann Arbor
Carroll, Catherine........................1130 Hill St., Ann Arbor
Carron, Dean P.................425 E. Washington, Ann Arbor
Cassidy, James T.............................618 Westwood, Ann Arbor
Cerny, Joseph C......... .....University Med. Ctr., Ann Arbor
Chatas, George J.....................106 Pleasant Pl., Ann Arbor
Child, Chas. G., III..............University Hospital, Ann Arbor
Christopher, Robt. P.......1500 Pauline, Apt. 408, Ann Arbor
Clifford, Mary Ellen........University Hospital, Ann Arbor
Clyde, Ensign E.........................1181 S. Main St., Plymouth
Cohan, Bruce E...............2355 E. Stadium Blvd., Ann Arbor
Conn, Jerome W.............200 Orchard Hill Dr., Ann Arbor
Corssen, Gunter.........................3490 Miller Rd., Ann Arbor
Crook, Clarence E.................2112 Wallingford, Ann Arbor
Cross, Thomas N.............Univ. Medical Center, Ann Arbor
Cummings, Howard H. (L)...................326 N. Ingalls St., Ann Arbor
Curtis, Arthur C.........................1313 E. Ann St., Ann Arbor
Curtis, Edward G.........1825 W. Stadium Blvd., Ann Arbor

Davenport, Fred. M.................1038 Martin Pl., Ann Arbor
Davey, Paula G.....................2620 Whitewood, Ann Arbor
Davey, Winthrop N.................1405 E. Ann St., Ann Arbor
Deatrick, Richard W.........2940 Hickory Lane, Ann Arbor
Decaires, Percy F. R.................700 Avon Rd., Ann Arbor
DeJong, Russell N.................1313 E. Ann St., Ann Arbor
DeJonge, Bud R.............................715 Plum St., Ann Arbor
DeKornfeld, T. J.................2581 Hawthorn Rd., Ann Arbor
Demuth, George R.....................Univ. Hospital, Ann Arbor
Den Houter, W. D.........1005 W. Ann Arbor Tr., Plymouth
DeTar, John S. (L).........................55 W. Main St., Milan
Diaz Perez, Rodrigo.....................2939 Renfrew, Ann Arbor
Dieterich, Gordon C.............820 E. University, Ann Arbor
Dillman, Richard S.....................1800 Baldwin, Ann Arbor
Dingman, Reed O.........................221 N. Ingalls, Ann Arbor
Dodson, Vernon N.........1638 University Hosp., Ann Arbor
Dolfin, Wilbur E.............................2210 Melrose, Ann Arbor
Domino, Edward F.........................3071 Exmoor, Ann Arbor
Douthat, Rudenz T.....................213 S. Ann Arbor St., Saline
Dryer, Clyde K...............................3033 Sophia St., Wayne
Dukay, Alexander P.........................2075 Fort Lincoln Park

Earle, Richard H.........................2119 Agin Ct., Ann Arbor
Edmunds, Wm. P.............................21 S. Prospect, Ypsilanti
Edwards, Melvin L., Jr...1521 Hatcher Crescent, Ann Arbor
Eliot, Johan W.................Sch. of Pub. Health, Ann Arbor
Elliott, Lyle D.................................26 S. Prospect, Ypsilanti
Engelke, Otto K. (L)................313 Washtenaw Co. Bldg., Ann Arbor
Evans, Tommy N...................1001 Belmont Rd., Ann Arbor

Fajans, Stefan S.........................248 Devonshire, Ann Arbor
Falk, Elwin C.................................14 N. Hamilton, Ypsilanti
Falls, Harold F.........................University Hosp., Ann Arbor
Farhat, Saeed M.....................826 Starwick Dr., Ann Arbor
Fayos, Juan V.............University Med. Center, Ann Arbor
Feller, Irving...............................2023 Devonshire, Ann Arbor
Fellman, S. L.....................2216 Medford Rd., Ann Arbor
Ferrington, R. A.............................519 W. Main St., Milan
Finch, Stuart M.........Child Psychiatric Hosp., Ann Arbor
Fink, Geo. C.........................411 N. Ingalls St., Ann Arbor
Fischmann, George................1321 Franklin Blvd., Ann Arbor
Fisher, Jos. V...Chelsea
Fischer, Robert J..............................1341 Jay Ave., Ypsilanti
Ford, Jack (A).........................3063 Williamsburg, Ann Arbor
Fox, Winslow G.................715 N. University, Ann Arbor
Fralick, F. Bruce................University Hospital Ann Arbor
Francis, Thos., Jr.........................U. Mich. Schl. Pub. Hlth., Ann Arbor
Fransway, Robt. L. (A)......2785 Park Ridge Dr., Ann Arbor
French, Arthur B.....................1113 W. Liberty, Ann Arbor
French, A. James.....................1313 E. Ann St., Ann Arbor
Frey, Charles F.........................1412 Russell Rd., Ann Arbor
Frohlich, Moses M.................1313 E. Ann St., Ann Arbor
Frost, Lyle W.................309 N. Washington St., Ypsilanti

Frye, Carl M..............................301 N. Ingalls, Ann Arbor
Furstenberg, A. C. (L)..........1313 E. Ann St., Ann Arbor

Gabrielsen, T. O. ....2341 Darrow Dr., Ann Arbor
Gamble, Robert N. (A)................608 Eberwhite, Ann Arbor
Garland, Donald M. (A)....2180 Fortress Rd., Drayton Plains
Garrison, D. Eugene..........................300 E. Henry, Saline
Gates, George A. (A)................U. Med. Center, Ann Arbor
Gerigk, Paul F..............................205 S. Davenport, Saline
Getting, Vlado A....................Sch. of Pub. Hlth., U. of M., Ann Arbor
Gignac, Ralph M........................32320 Michigan, Wayne
Gikas, Paul W............................V.A. Hospital, Ann Arbor
Ging, Rosalie J.............Veterans Adm. Hosp., Ann Arbor
Glenn, Edward A. (A)................2827 Briarcliff, Ann Arbor
Goldsmith, Robt. I...................216 Mich. Theatre Bldg., Ann Arbor
Gosling, J. R. G.............................315 Corrie Rd., Ann Arbor
Gottlieb, Joel D........................1800 Traver Rd., Ann Arbor
Gotz, Alexander....................2201 Medford Rd., Ann Arbor
Gould, Stuart M., Jr................Mercywood Hosp., Box 65, Ann Arbor
Grabb, William C.................221 N. Ingalls St., Ann Arbor
Gracie, Wm. A., Jr.............2441 Shannondale, Ann Arbor
Graves, Wm. H., III.................1 Medford Circle, Ann Arbor
Greene, James A., Jr.......251 Orchard Hills Rd., Ann Arbor
Grillo, S. Phillip...............................265 Main St., Belleville

Habel, Dan W. (M)..Keesler AFB Hosp., Keesler AFB, Miss.
Hagerman, Geo. W.............321 N. Ingalls St., Ann Arbor
Haig, Owen G. (A)............2803 Towner Blvd., Ann Arbor
Haight, Cameron....................1313 E. Ann St., Ann Arbor
Hammond, Walter W., Jr.................221 N. Sheldon Rd., Plymouth
Hampshire, John K. (A)........1018 Woodbridge, Ann Arbor
Handorf, Heinrich H.....................Penniman Allen Theatre, Northville
Hankamp, Lamar J.................2119 Woodside, Ann Arbor
Hannum, Marvin R.................................54 W. Main, Milan
Hanson, Frederick N.......171 Yorkshire Blvd., Dearborn Hts.
Harrell, E. R., Jr.....................1313 E. Ann St., Ann Arbor
Harris, Bradley M.........................27 S. Prospect, Ypsilanti
Harris, Scott T.....................44490 Clare Blvd., Plymouth
Harrison, Saul I.........Child Psychiatric Hosp., Ann Arbor
Harrison, Timothy S.........................University Med. Center, Ann Arbor
Hartman, Robt. T.................................519 W. Main, Milan
Hayes, John T..........................326 N. Ingalls St., Ann Arbor
Henderson, John W.............University Hosp., Ann Arbor
Hendrix, Robt. C.................1139 Vesper Rd., Ann Arbor
Henry, L. Dell....................706 W. Huron St., Ann Arbor
Heyner, Fredk. J.................................3424 Oakman, Detroit
Hicks, Samuel P................1112 Meadowbrook, Ann Arbor
Hildebrandt, H. Mark...................1130 Hill St., Ann Arbor
Himler, Leonard E.........1225 Fairoaks Pkway., Ann Arbor
Hinerman, Dorin L.................1313 E. Ann St., Ann Arbor
Hing, Ng Harry.........St. Joseph Mercy Hosp., Ann Arbor
Hinko, Edward......4110 Meadowbrook, Univ. Heights, Ohio
Hiraga, Mikio H....................2433 Colony Ct., Ann Arbor
Hiss, Roland G. (A)............716 N. Maple Rd., Ann Arbor
Hoag, Robert D. (M)........Naval Hospital, Annapolis, Md.
Hodges, Fred J. (L).............5 Highland Lane, Ann Arbor
Holmes, Donald J............505 Barton North Dr., Ann Arbor
Holt, John F.............................1313 E. Ann St., Ann Arbor
Holtz, Fred...............................326 N. Ingalls, Ann Arbor
Hoskins, Phillip A. (A)........824 Edgewood Pl., Ann Arbor
House, Frederic B.........1240 Crosby Crescent, Ann Arbor
Howard, Stacy C. (R)..........Rt. 3, Box 6571, Orlando, Fla.
Howard, W. Leonard....................Maybury San, Northville
Howatt, William F...........University Hospital, Ann Arbor
Hubbard, Wm. N., Jr.................Univ. of Mich. Med. Sch., Ann Arbor
Huizenga, Philip B...Box A, Ypsilanti
Hulett, Ralph M.............1444 Glastonbury Rd., Ann Arbor
Hyman, Saml. J.....................27342 Michigan Ave., Inkster

Ideson, Robt. S., II................122 N. Thayer St., Ann Arbor

Jacob, Jos. S.................202 E. Washington St., Ann Arbor
Jeffries, Frank W.....................2200 Fuller Rd., Ann Arbor
Jender, Joseph G.....................1302 W. Maple St., Plymouth
Jimenez, B. (R)....................215A S. Main St., Ann Arbor
Johnson, Robt. D................3432 Woodlea Dr., Ann Arbor
Johnston, Franklin D..............1313 E. Ann St., Ann Arbor
Jones, Elizabeth..................2121 Highland Rd., Ann Arbor
Judge, Richard D.........Univ. Medical Center, Ann Arbor
Julian, Mark D.............................740 S. Emerick, Ypsilanti

Kabza, Theodore G.................326 N. Ingalls, Ann Arbor
Kahn, Edgar A.........................500 Burson Pl., Ann Arbor
Kambly, Arnold H., Jr.............201 S. Main St., Ann Arbor
Karat, Leslie G.....................124 Longman Lane, Ann Arbor
Kaufer, Herbert (M)....22 D. Shibe Terrace, Vineland, N. J.
Kaump, Donald H.............2800 Plymouth Rd., Ann Arbor
Keese, Antonia J.................705 N. University, Ann Arbor
Kelley, Jack L. (A).........................1208 Prospect, Ann Arbor
Kelley, Paul A............................326 N. Ingalls, Ann Arbor
Kemp, W. R., Jr....................................8124 Main St., Dexter
Kemph, John P.................................521 Hillspur, Ann Arbor
Kerlikowske, A. C................1313 E. Ann St., Ann Arbor
Kern, Wheeler H.............2011 Middlebelt Rd., Garden City
Kerry, Robert L.....................2695 Appleway, Ann Arbor
Kershul, Victor W.......................................Box A, Ypsilanti
Kheder, Jamil.........................44526 Clare Blvd., Plymouth
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Kindt, Glenn W. (A)............Univ. Med. Center, Ann Arbor
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Berman, Lawrence........................1401 Rivard St., Detroit 7
Berman, Robt. H...........................2111 Woodward, Detroit 1
Berman, Sidney L..........................60 W. Hancock, Detroit 1
Bernard, Walter G..........................910 Chalmer, Detroit 15
Bernbaum, Bernard...................17320 Livernois, Detroit 21
Bernstein, Saml. S.......................18200 Wyoming, Detroit 21
Bernys, Conrad F.......1317 David Whitney Bldg., Detroit 26
Berridge, William L.................Chevrolet Motor Co., Livonia
Berry, Jos. E.......................19242 W. 7 Mile Rd., Detroit 19
Bertram, Karl R.................2930 W. Grand Blvd., Detroit 2
Besancon, John H.............1510 Broderick Tower, Detroit 26
Best, Thos. H. E. (L).........9221 E. Jefferson Ave., Detroit 14
Betanzos, G................................11477 12 Mile Rd., Warren
Bialik, Michael H..................14853 Michigan Ave., Dearborn
Bicknell, Frank B.......938 David Whitney Bldg., Detroit 26
Bielawski, John G.......825 David Whitney Bldg., Detroit 26

Bigman, Oscar........................18400 Schaefer Rd., Detroit 35
Bihl, John H...............15800 W. McNichols Rd., Detroit 35
Billingslea, Thos. H.................2175 Willis Ave. E., Detroit 7
Bing, Richard J...............................1401 Rivard St., Detroit 7
Bins, Philip M............................573 Fisher Bldg., Detroit 2
Birch, John R.............925 David Whitney Bldg., Detroit 26
Birk, Robert E.......................Henry Ford Hospital, Detroit 2
Birkam, Fred F.........................7301 Schaefer Rd., Dearborn
Birkhill, F. Ross..................31 Shady Hollow Dr., Dearborn
Birmingham, D. J.......................Wayne State Univ., Detroit
Birmingham, John R.....14215 W. McNichols Rd., Detroit 35
Birndorf, Leonard...........................18317 John R St., Detroit 3
Bittker, Isadore I. (L)........3321 Rochester Rd., Royal Oak
Bittrich, Norbert M.............16001 9 Mile Rd., Southfield
Black, Earl D.............20867 Mack Ave., Grosse Pointe 36
Black, Robert W.........641 David Whitney Bldg, Detroit 26
Blain, Alexander, III.................2201 E. Jefferson, Detroit 7
Blain, Donald G.........841 Balfour Rd., Grosse Pointe Park
Blain, James H., Jr................119 Kercheval Rd., Detroit 36
Blaine, Max.................................13700 Woodward, Detroit 3
Blair, Wm. F..................................81 E. Kirby St., Detroit 2
Blanchard, Russell S.............12858 Woodward Ave., Detroit
Blanks, Douglas H......................3955 Fort St., Lincoln Park
Blass, Norman H...............................1800 Tuxedo, Detroit 6
Blatt, Ronald W...............300 Cadillac Sq. Bldg., Detroit 26
Bleier, Alfred.....................13015 E. Warren Ave., Detroit 15
Blinkhorn, David H.................3494 Ewald Circle, Detroit 1
Block, Duane L............................3001 Miller Rd., Dearborn
Block, Melvin A...................2799 W. Grand Blvd., Detroit 2
Blodgett, James B.....................76 W. Adams St., Detroit 26
Blodgett, Wm. E. (L)...............76 W. Adams St., Detroit 26
Blodgett, Wm. H...................74 W. Adams Ave., Detroit 26
Blondy, Marshall J...........19009 W. 7 Mile Rd., Detroit 19
Bloom, Albert..............................6484 Chene St., Detroit 11
Bloom, Arthur R.........................19140 Gloucester, Detroit 3
Bloom, Victor..............................951 E. Lafayette, Detroit 7
Bloomberg, Sanford............18916 Woodward Ave., Detroit 3
Bloor, Robt. J............................Henry Ford Hosp., Detroit 2
Bluhm, Gilbert B.................Henry Ford Hospital, Detroit 2
Blum, George L.........................18200 Wyoming, Detroit 21
Blumenthal, Frank S..............................261 Brady, Detroit 1
Blumenthal, Franz L. (L)....2686 Heatherway, Ann Arbor
Blumer, Abraham........21415 W. Eight Mile Rd., Detroit 19
Boccaccio, John L........................11532 Morang, Detroit 24
Boccia, James J.........................15761 E. Warren, Detroit 24
Boddie, Arthur W..........................2737 Chene St., Detroit 7
Bogucki, Chester J.............18620 Walmer Lane, Birmingham
Bogue, Robt. E...........15800 W. McNichols Rd., Detroit 35
Bogusz, Ladislaus (R)...........................29215 Maranya Rd., Homestead, Fla.
Bohn, Z. Stephen................327 Professional Bldg., Detroit 1
Bohne, A. Waite........................Henry Ford Hosp., Detroit 2
Boland, John R. (R)...........................Box 50, Grand Marais
Boles, Murray....................26381 Dundalk Lane, Farmington
Bolstad, Donald S.....................Henry Ford Hosp., Detroit 2
Bolter, Sidney......................18946 W. McNichols, Detroit 19
Bolton, Norman..................................19467 Livernois, Detroit
Bolton, Russel P., Jr.....18530 Grand River Ave., Detroit 23
Boman, Robert H...................12650 E. Outer Dr., Detroit 24
Bookstein, Abraham M.............1725 Pinecrest Dr., Ferndale
Boone, Geo. F...1328 Joliet, Detroit
Borchak, Robert G..................12408 Van Dyke, Detroit 34
Borden, Igor I.....................15361 Plymouth Rd., Detroit 27
Borin, Maurice C...................18115 Fairfield St., Detroit 21
Bornstein, M.................17600 Northland Pk. Ct., Southfield
Bornstein, Sidney.................................2033 Puritan, Detroit 3
Borrego, Jose M.......................1342 Whittier, Grosse Pointe
Bott, Edmund T..................................1629 Ford, Wyandotte
Botvinick, Isadore..............13701 W. 7 Mile Rd., Detroit 35
Boutros, Nabil R.........15300 McNichols Rd. W., Detroit 35
Boutrous, Thos. A.............15801 W. McNichols, Detroit 35
Bower, Donald W.............................719 Liberty, Lincoln Park
Bowers, Leo J...............11200 E. McNichols Rd., Detroit 34
Bowersox, Leroy W.........765 Balfour Rd., Grosse Pte. Pk.
Bowlby, James R...................15420 Farmington Rd., Livonia
Bownes, Eugene A.................18520 Grand River, Detroit 23
Boyajian, Albert...........................10963 Farmington, Livonia
Boyd, Albert L..................................21124 Goddard, Taylor
Boyd, John H..............................2615 W. Jefferson, Trenton
Boyle, Albert J.....................Wayne St. University, Detroit 2
Boyle, Eugene H......................................572 Thorn Tree Rd., Grosse Pointe Woods

Boyle, Robert E..........P.O. Drawer B, Stevensville
Bracken, Andrew H..........5460 Schaeffer, Dearborn
Braden, Robt. G..........2300 Oak St., Wyandotte
Bradfield, Horace F..........3008 E. Grand Blvd., Detroit 2
Bradley, Geo. T..........1553 Woodward Ave., Detroit 26
Braley, Wm. N. (L)..........12897 Woodward, Detroit 3
Bramigk, Fritz W. (L)..........509-511 Professional Bldg., Detroit 1
Brand, Benj..........4500 Wabash Ave., Detroit 8
Brandl, Earl A..........2860 Clark, Detroit 32
Braun, Lionel..........15121 W. McNichols Rd., Detroit 35
Braun, Robert A..........18610 Hartwell Ave., Detroit 35
Braverman, Morris M...20905 Greenfield Rd., Southfield 35
Bredau, Frank N., Jr..........24781 Five Mile Rd., Detroit
Breiner, Sander J..........14300 W. McNichols Rd., Detroit 21
Brekke, Viola G..........369 Glendale St., Highland Park 3
Bremer, John P..........17818 E. Warren, Detroit 24
Bremer, Wm. M..........15641 E. Warren, Detroit 24
Breneman, Gerald M..........28300 Forest Brook Dr., Farmington
Brennan, Louis G. (A)....Mt. Carmel Mercy Hosp., Detroit
Brennan, Michael J.....1168 Three Mile Dr., Grosse Pointe
Brent, Morris S..........1330 Strathcona Dr., Detroit 3
Brey, Norman W..........1900 David Broderick Twr., Detroit 26
Briegel, Walter A. (R)..........3233 N.E. 34th St., Ft. Lauderdale, Fla.
Briggs, Wm. J..........1900 David Broderick Twr., Detroit 26
Bringard, Elmer L..........20905 Greenfield, Southfield
Brinkman, G. L..........Henry Ford Hospital, Detroit 26
Briski, Jacob E..........1058 Blairmoor, Grosse Pte. Woods
Brisson, John E..........14801 Southfield, Allen Park
Brisson, Jos. C. (R)..........9191 Whittier St., Detroit 24
Bristol, Wm. R..........189 Claverly, Detroit 36
Broadman, Sylvan A..........25705 Middlebelt, Farmington
Brock, Donald R..........36475 Five Mile Rd., Livonia
Broderson, Harvey S. (R)..........10720 W. Jefferson, River Rouge 18
Bromme, Wm. (L)..........10 Peterboro St., Detroit 1
Brooks, Chas. W., II..........2033 E. Davison St., Detroit 12
Brooks, Eugene M.......609 Northland Med. Bldg., Southfield
Brooks, Nathan..........7401 3rd St., Detroit 2
Brosius, Chas. O..........15800 Six Mile Rd., Detroit 35
Brosius, Wm. L. (L)..........1823 Fair Oak Court, Rochester
Brown, Andrew G..........20905 Greenfield, Southfield
Brown, Audrey O. (L)....1795 Cedar Hill Dr., Birmingham
Brown, Carlton F..........16552 Westmoreland Rd., Detroit 19
Brown, Chas. H..........2387 Fort St., Wyandotte
Brown, Eli M..........13123 LaSalle, Huntington Woods
Brown, Frances (L)..........1940 Lincolnshire, Detroit 3
Brown, Gordon T..........13000 Hayes Ave., Detroit 5
Brown, Henry S. (L)..........100 Oakman Blvd., Detroit
Brown, John R..........1145 David Whitney Bldg., Detroit 26
Brown, Kenneth A..........5050 Joy Rd., Detroit 4
Brown, Oscar A..........1633 Dav. Whitney Bldg., Detroit 26
Brown, Robt. A..........3529 W. Jefferson Ave., Ecorse
Brown, Saml. M..........21821 Harding, Oak Park
Brown, Saul..........6890 White Pine Dr., Birmingham
Brown, Stanley H. (L)..........8544 W. McNichols Rd., Detroit 21
Brown, Thos. A..........5430 W. Warren Ave., Detroit 10
Brownell, H. H..........8222 Woodcrest Dr., Grosse Ile
Brownell. Paul G..........18916 Woodward Ave., Detroit 3
Bruce, Thomas A..........19540 Shrewsbury, Detroit 21
Bruder, Robt. C..........4520 Firestone Ave., Dearborn
Bruer, Edgar S..........12170 Fort St., Wyandotte
Bruer, Edwin L..........12170 Fort St., Wyandotte
Brundage, Robt. D..........1914 Edgewood, Dearborn
Brush, Brock E..........2799 W. Grand Blvd., Detroit 2
Bruton, Martin F..........341 Massachusetts, Detroit 31
Bryan, Donald I.....13700 Woodward Ave., Highland Park 3
Bryan, John B..........4045 W. 13 Mile Rd., Royal Oak
Buck, Raymond E..........1575 E. Lafayette, Detroit 7
Buell, John H. (R)..........188 Provencal Rd., Detroit 36
Buerki, Robin C..........Henry Ford Hosp., Detroit 2
Buettgen, Jan W..........2900 S. Fort St., Detroit 17
Buller, Harry L. (A)..........16120 Greenview Ave., Detroit 38
Burge, Robert H..........28343 Joy Rd., Dearborn
Burke, Ralph M..........580 University Pl., Grosse Pointe 30
Burnham, Thomas K..........Henry Ford Hospital, Detroit 2
Burns, Robert E..........Henry Ford Hospital, Detroit 2
Burns, Robt. T..........11110 Morang Rd., Detroit 24
Burnside, Howard B..........33 Oakland Park, Pleasant Ridge
Burnstine, David..........771 Fisher Bldg., Detroit 2
Burnstine, Julius Y. (L)..........45 Owen Ave., Detroit 2
Burnstine, Perry P..........2329 W. Grand Blvd., Detroit 8
Burr, Geo. C. (L)..........1177 Devonshire, Grosse Pointe
Burroughs, Roswell G..........31624 Auburn Dr., Birmingham
Burrows, Howard A..........10423 W. Warren Ave., Dearborn
Burstein, Harry S..........2950 W. Grand Blvd., Detroit 2
Burstein, I. Marvin..........2950 W. Grand Blvd., Detroit 2
Burstein, Morris M..........2950 W. Grand Blvd., Detroit 2
Burton, DeWitt T. (L)..........54 Arden Park, Detroit 2
Burton, Irving F..........26912 York Rd., Huntington Woods
Burton, John F..........400 E. Layfayette, Detroit
Bush, Glendon J..........18901 W. McNichols, Detroit 19
Butler, Harry J. (L)..........33 Waverly Ave., Highland Park
Butler, James E..........2177 W. Grand Blvd., Detroit 8
Butler, John D..........2173 W. Grand Blvd., Detroit 8
Butler, J. Payne..........3403 W. Warren St., Detroit 8
Butler, Lawrence H..........14521 East 7 Mile Rd., Detroit 5
Butler, Richard G..........2021 Monroe, Dearborn
Butler, Volney N..........28 W. Adams Ave., Detroit 26
Buttrum, Edward J..........14755 Fenkell St., Detroit 27
Byers, Dudley W. (A)..........8934 Oakland, Detroit 11

Cabral, Hector H..........13015 W. Chicago, Detroit 28
Cabrera, Enrique..........27459 W. Warren, Garden City
Cadger, Ralph E..........719 New Center Bldg., Detroit 2
Cahalan, Jos. L..........15830 Fort St., Southgate
Cain, Waldo L..........8401 Woodward Ave., Detroit 2
Caldwell, Geo. L. (L)....12017 Joseph Campau, Detroit 12
Caldwell, John R..........2799 W. Grand Blvd., Detroit 2
Callaghan, Regis L..........22146 Ford Rd., Dearborn
Cameron, Arthur H. (L)..........2853 Biddle Ave., Wyandotte
Cameron, Duncan A..........2021 Monroe, Dearborn
Campbell, Duncan (L)..........330 Bush St., Apt. 1, Howell
Campbell, Fredk. W., Jr.....Henry Ford Hospital, Detroit 2
Campbell, Harvey E..........3 Robindale Ct., Dearborn
Campbell, Malcolm D. (L)..........14950 Forrer, Detroit 27
Campbell, Mary B. (L)..........10454 Kingston, Huntington Woods
Campbell, Robt. E..........8445 E. Jefferson Ave., Detroit 14
Campbell, Ruth B..........1536 David Whitney, Detroit 26
Campbell, Thelma M..........2355 Monroe Blvd., Dearborn
Camps, Enrique (A)..........12950 W. Chicago, Detroit 28
Cancino-Samson, E..........4777 E. Outer Drive, Detroit 34
Candler, Clarence L. (L)..........815 Brown St., St. Clair
Canter, Gayle E..........13700 Woodward Ave., Detroit 3
Cantor, Herbert C..........26831 N. Woodward, Huntington Woods
Cantor, Meyer O..........7850 Charing Cross, Bloomfield Hills
Cantow, Lawrence A.......19291 Warrington Dr., Detroit 21
Capellari, Elmer E..........Box 3059, Detroit
Capobres, David B..........1800 Tuxedo, Detroit 6
Caputo, Jos. M..........21831 Willoway, Dearborn
Caputo, Nancy T..........17712 Mack Ave., Grosse Pointe 30
Capuzzi, Eugene T..........24644 Gleneyrie Dr., Southfield
Caraway, James E. (R)......Rt. 1, Box 503, Franklin, N. C.
Carbone, Louis..........14711 Gratiot Ave., Detroit 5
Carbonell, Tomas..........353 Devonshire, Dearborn
Carlisle, John C..........15101 Southfield, Allen Park
Carlson, Harold W..........18070 Wildemere Ave., Detroit 21
Carnes, Harry E. (A)..........Parke Davis Co., Detroit 32
Carp, Jos..........8717 Van Dyke, Detroit 13
Carpenter, C. J. (L)..........P.O. Box 390, Wayne
Carpenter, Glenn B. (L)..........2751 W. Seven Mile Rd., Detroit 21
Carpenter, Wm. S.......18255 W. McNichols Rd., Detroit 19
Carr, James G. (L)..........14111 Korte, Detroit 15
Carrick, Lee..........18050 Mack Ave., Grosse Pointe
Carroll, Elmer H..........9920 Stoepel Ave., Detroit 4
Carroll, Jerome G..........29588 Five Mile Rd., Livonia
Carroll, Lona B. (L)..938 David Whitney Bldg., Detroit 26
Carson, Herman J..........7745 Puritan Ave., Detroit 38
Carstens, Henry R. (L)..........6896 N. Clunbury Rd., Birmingham
Carter, James A. U..........16637 Wildemere, Detroit 21
Carter, John M. (L)..........2860 N.E. 55th Court, Ft. Lauderdale, Fla.
Carter, Leland F..........750 Middlesex, Detroit 30
Case, Hilda B..........261 Mack Blvd., Detroit 1

Cash, Ralph..........19316 James Couzens, Detroit 35
Cassel, Harry E..........6742 Park Ave., Allen Park
Castle, Maurice E..........18980 Wyoming, Detroit 21
Caughey, Andrew F., Jr..........20041 W. Eight Mile Rd., Detroit 19
Caughey, Edgar H..........11301 Whittier St., Detroit 24
Caumartin, Fred E..........17184 Wildemere, Detroit 21
Cellar, Frank A., Jr..........26789 Woodward Ave., Royal Oak
Ceravolo, Albert J..........468 Cadieux Rd., Detroit 30
Ceresko, Anthony R..........9187 Mason Place, Detroit 9
Cetnar, Eugene J..........4322 Bishop, Detroit 24
Chajes, Richard..........15684 Joy Rd., Detroit
Chalat, Ned I..........1553 Woodward Ave., Detroit 26
Chall, Henry G..........2941 W. McNichols Rd., Detroit 21
Chapin, Sidney E..........125 N. Military, Dearborn 7
Chapman, Aaron L. (L)..........406 W. Frisco Rd., Pensacola, Fla.
Chapman, Paul T..........1151 Taylor Ave., Detroit 2
Chapman, Roland H..........7600 John R St., Detroit 2
Chapman, Thomas H..........18901 Grand River Ave., Detroit 23
Chapnick, Henry A..........19335 Prairie, Detroit 21
Chapper, Barbara M..........861 Monroe, Dearborn
Charnas, Sidney..........1129 David Whitney Bldg., Detroit 26
Charnley, Arnold D..........1678 Merriman Rd., Wayne
Chase, Clyde H. (R)..........2922 Dawes St. S.E., Grand Rapids 8
Chason, Jacob L..........1401 Rivard St., Detroit 7
Chavis, William M..........15866 12th St., Detroit 21
Check, Frank E..........76 W. Adams Ave., Detroit 26
Chen, Allen S. Y..........Wayne Co. Gen. Hosp., Eloise
Chen, Calvin H..........State Hosp., Northville
Chen, Shek C..........1326 St. Antoine, Detroit 26
Chen, Vincent V..........987 E. Jefferson, Detroit 7
Cherenzia, B. J..........Highland Pk. Gen. Hosp., Highland Pk.
Chesluk, Herman M..........17191 J. Couzens Hwy., Detroit 35
Chester, Alice..........25085 Coolidge Hwy., Oak Park
Chester, Wm. P..........28 W. Adams Ave., Detroit 26
Childs, Geo. M..........2970 W. Grand Blvd., Detroit 2
Chipman, Willard A..........14300 W. McNichols Rd., Detroit 35
Chipoco, Adolfo M..........25210 Grand River, Detroit 40
Chadorkoff, Bernard..........19435 Shrewsbury, Detroit 21
Chostner, Grover C. (R)..........841 Eden Isle Blvd., St. Petersburg, Fla.
Chown, Marion C..........2025 Ford, Wyandotte
Christensen, R. C..........20861 Mack, Grosse Pointe Woods
Christopher, James G..........4777 E. Outer Dr., Detroit 34
Chrouch, Laurence A. (L)..........Pleasant Hill, Tenn.
Church, Aloysius S..........19570 Bretton Dr., Detroit 23
Churchill, John A..........Lafayette Clinic, Detroit 7
Cioffari, Mario S..........15924 W. Seven Mile Rd., Detroit 35
Ciprian, Jos. E. (L)..........1775 E. Grand Blvd., Detroit 11
Clapper, Muir..........1401 Rivard St., Detroit 7
Clark, Arthur M..........401 River Lane, Dearborn
Clark, Clarence M. (L)..........2605 Holbrook Ave., Detroit 12
Clark, Harold E. (L)..........30761 Greenfield Rd., Southfield
Clark, Max D..........Henry Ford Hospital, Detroit 2
Clark, Wm. P..........1808 Baldwin, Ann Arbor
Clarke, Chas. N..........2501 W. Grand Blvd., Detroit 8
Clarke, Norman E. (L)..........2501 W. Grand Blvd., Detroit 8
Clarke, Norman E., Jr..........2501 W. Grand Blvd., Detroit 8
Clarke, Robt. B..........76 W. Adams Ave., Detroit 26
Clemens, Raymond R..........23843 Joy, Dearborn
Clermont, Volna..........5050 Joy Road, Detroit 4
Clifford, John E..........18348 Mack, Detroit
Clifford, Thos. P. (L)..........1750 David Whitney Bldg., Detroit 26
Climie, Andrew R. W..........Harper Hospital, Detroit 1
Cline, Richard S..........15101 Plymouth Rd., Detroit 27
Clune, John P..........226 Professional Bldg., Detroit 36
Coates, E. Osborne, Jr..........Henry Ford Hospital, Detroit 2
Cobane, John H..........10 Peterboro Ave., Detroit 1
Cochrane, Edgar G..........503 Med. Arts Bldg., Detroit 3
Cocorelis, S. G. (A)..........No Address
Cohen, Herbert H..........12700 W. 7 Mile Rd., Detroit 35
Cohen, Melvin F..........20905 Greenfield, Southfield
Cohn, Danl. E..........409 Fox Bldg., Detroit 1
Cohn, Leonard S..........19105 W. Seven Mile Rd., Detroit 19
Cohoe, Don A. (L)..........18916 Woodward Ave., Detroit 3
Cole, James E. (L)..........344 Glendale Ave., Detroit 3
Cole, Wyman C. C. (L)..........1063 Fisher Bldg., Detroit 2
Cole, Wyman C. C., Jr..........3011 W. Grand Blvd., Detroit 2
Coleman, Margarete W. (L)..........1209 S. Woodward, Royal Oak
Coleman, Peter F..........31410 Joy Rd., Livonia
Coleman, Wm. G..........20526 Grand River Ave., Detroit 19
Coles, Thomas B., Jr..........Grace Hospital, Detroit 1
Collier, Beverly A..........Henry Ford Hosp., Detroit 2
Collier, Richard L..........Henry Ford Hosp., Detroit
Collings, M. Raymond (A)..........9201 W. Outer Dr., Detroit 19
Collins, James E..........13103 W. Chicago Blvd., Detroit 28
Collins, James W..........15870 Twelfth St., Detroit 38
Colvin, Leslie T..........3011 W. Grand Blvd., Detroit 2
Colyer, Raymond G. (R)..........284 Pilgrim, Birmingham
Combs, Julius V..........2424 Puritan, Detroit 38
Comly, Hunter H..........5475 Woodward, Detroit 2
Compton, Wm. A., Jr..........36825 Bibbins, Romulus
Comstock, Lawrence A..........3700 West Rd., Trenton
Conklin, Emma J..........Wayne Co. Gen. Hosp., Eloise
Conley, Lowry C. M. (L)..........99 Tuxedo Ave., Detroit 3
Connelly, Richard C..........1360 3 Mile Rd., Grosse Pte.
Connolly, Paul J..........16778 Westmoreland Rd., Detroit 19
Connors, John J..........25657 Southfield Rd., Southfield
Cook, Carla A. (A)..........1300 Lafayette East, Detroit 7
Cook, James A..........2246 20th St., Wyandotte
Cook, James C..........3825 Brush St., Detroit 1
Cookinham, Frank..........999 S. Highland, Dearborn
Cooksey, Warren B. (L)..........801 Adams Rd., Birmingham
Cooper, James B..........18150 Mack Ave., Grosse Pointe 30
Cooper, Ralph R..........850 Lakeland, Grosse Pointe 30
Cooper, Richard F..........1245 David Whitney Bldg., Detroit 26
Corbeille, Catherine (L)..........3011 W. Grand Blvd., Detroit 2
Corbett, David P..........Harper Hospital, Detroit 1
Cortez, Joseph A..........19350 W. McNichols, Detroit 15
Costa, Frank..........17032 Fort St., Riverview
Costello, Russell T..........3001 W. Grand Blvd., Detroit 2
Costello, Stephen D..........9435 Island Dr., Detroit 35
Cotant, John F..........14044 W. McNichols, Detroit 35
Cotton, Schuyler O. (R)..........7904 Vernor Hwy., Detroit 9
Courville, Chas. J..........703 Northland Med. Bldg., Southfield
Cowan, Wilfrid (L)..........14239 Chandler Pk. Dr., Detroit 13
Cowen, Leon B. (L)..........1001 Kales Bldg., Detroit 26
Cowen, Robt. L. (L)..........91 E. Kirby, Detroit 2
Cox, Frank, Jr..........Henry Ford Hosp., Detroit 2
Coyle, James E..........573 Fisher Bldg., Detroit 2
Craig, Roy D..........829 Fisher Bldg., Detroit 2
Craig, Roy E..........74 Fontana Lane, Grosse Pointe Shores
Crawford, Robert I. (A)..........Lyons
Crawley, Eugene H..........885 Bloomcrest, Birmingham
Crews, Thos. H. (L)..........3011 W. Grand Blvd., Detroit 2
Crockett, E. E. J..........7341 W. Warren, Detroit 10
Croll, Leo J..........12703 W. 7 Mile Rd., Detroit 35
Croll, Maurice..........12703 W. Seven Mile Rd., Detroit 35
Crook, Chas. L..........60 Colorado St., Highland Park 3
Cross, Harold E..........68 N. Deepland Rd., Grosse Pointe
Crossen, Robert J..........933 David Whitney Bldg., Detroit
Crossman, Lyman W..........Delray Hospital, Detroit 17
Croushore, James E..........3001 W. Grand Blvd., Detroit 2
Cubberly, Robt. B..........1800 Tuxedo St., Detroit 6
Cueto, Jose M..........23200 Woodward, Ferndale
Cullis, Frank..........261 Brady, Detroit 1
Curhan, Jos. H..........18709 Meyers Road, Detroit 35
Curhan, Robert P..........18709 Meyers Rd., Detroit 35
Curtis, Frank E. (L)..........273 Kenwood Ct., Detroit 36
Curtiss, Wm. P..........22631 Mack Ave., St. Clair Shores
Cusick, Paul L..........1108 Stroh Bldg., Detroit 26
Daignault, F. M..........20905 Greenfield, Southfield
Daitch, Harold J..........22341 W. 8 Mile Rd., Detroit 19
Daitch, Martin H..........13011 W. McNichols Rd., Detroit 35
Dale, Esther H..........1401 Rivard St., Detroit 7
Dale, Mark..........3702 E. 8 Mile Rd., Detroit 34
Dal Santo, G..........1401 Rivard St., Detroit 7
Daly, Eugene T..........24781 Fenkell, Detroit 29
Danforth, James C., Jr..........20175 Mack Ave., Detroit 36
Danforth, Robt. D..........20175 Mack Ave., Detroit 36
Danielski, John J..........563 Fisher Bldg., Detroit 2
Danto, Bruce L..........18516 Hartwell, Detroit
Danz, George W..........1539 Ford, Wyandotte
Daoust, Patrick H..........15520 Garfield, Allen Park
Darling, Chas. E..........673 Fisher Bldg., Detroit 2
Darnley, James D..........24 Fairwood Blvd., Pleasant Ridge
Dashiell, Grayson F..........1800 Tuxedo, Detroit 6
Davidson, Harold H..........19310 Wyoming, Detroit
Davidson, Harry O..........2799 W. Grand Blvd., Detroit 2

Davies, Thos. S. (L)...15115 E. Jefferson, Grosse Pointe 30
Davies, Windsor S...28 W. Adams Ave., Detroit 26
Davis, Herbert A...9901 Melbourne, Allen Park
Dawson, W. A. (R)...188 Lake Silver Dr. N.W., Winter Haven, Fla.
Day, A. Jackson...245 Cloverly Rd., Detroit 36
Day, Francis T...18540 Mack, Detroit 36
Day, Jay C...1553 Woodward Ave., Detroit 26
Deaenlle, Eliodoro...No. Detroit Gen. Hosp., Detroit
Dean, Carleton R. (M)...Off. of Vocnl. Rehab., 42 Broadway, Room 1200, New York 4, N. Y.
Dean, George A...19309 Greenfield, Detroit 35
De Busk, Roger W...4160 John R St., Detroit 1
Deering, Robt. J...1359 Champaign, Lincoln Park
Defever, Cyril R...19787 Mack Ave., Detroit 36
De Giustino, Caesar...1175 E. Grand Blvd., Detroit 11
De Groat, Albert F...1151 Taylor Ave., Detroit 2
De Jongh, Edwin...Gen. Motors Bldg., Detroit
Delaini, Stella M...3011 W. Grand Blvd., Detroit 2
De Lawrence, Betty J...21576 Michigan Ave., Dearborn
De Lawrence, Thomas...21576 Michigan Ave., Dearborn
Del Giorno, Thos. E...St. John's Hospital, Detroit 36
DelGiudice, P. A...Grace Hosp., Detroit 1
Del Valle, Mario...19936 Packard, Detroit 34
Dennis, Melvin S...22146 Ford Rd., Dearborn
Denson, Andrew L. (A)...821 Medical Group, Ellsworth AFB, S. Dak.
Deponio, Sylvester A...20215 Van Dyke Ave., Detroit 34
Deresz, Alphonse...4204 E. Outer Dr., Detroit 34
Derleth, Paul E...563 W. Oakridge Ave., Ferndale 20
Derr, John W...1145 David Whitney Bldg., Detroit 26
Derrick, C. F...3677 Fort St., Lincoln Park
Deryke, Gilbert R...13535 Salem, Detroit
De Smyter, Geo. C...15527 E. Warren, Detroit 24
De Spelder, Ray E...2970 W. Grand Blvd., Detroit 2
Deuby, Owen J...15121 W. Seven Mile Rd., Detroit
Devine, Herbert W...22101 Moross Rd., Detroit 36
Diakow, Lilian M...1539 N. Line Rd., Wyandotte
Dibble, Harry F. (L)...1553 Woodward Ave., Detroit 26
Dickson, Basil R...337 W. Grand Blvd., Detroit 16
Dickson, Elias L., Jr...7716 Oakland Ave., Detroit 11
Dickson, Laurie C., Jr...400 Lincoln Rd., Grosse Pointe 30
Dickson, Leon A...5535 W. Chicago, Detroit 4
Dickson, Mary D...18424 Mack Ave., Grosse Pointe 36
Diebel, Nelson W...660 Cadieux Rd., Detroit 30
Diekman, Fred C...31815 Southfield Rd., Birmingham, Mich.
Dietze, Margaret R...861 Monroe, Dearborn
Dietzel, Hugo O. (R)...844 Hemlock Dr., San Carlos, Calif.
Di Lella, Leonard L...Henry Ford Hospital, Detroit 2
Dill, Hugh L...16114 E. Warren Ave., Detroit 24
Dill, J. Lewis...18615 Birchcrest, Detroit 21
Di Loreto, Panfilo C...285 Vincennes Pl., Detroit 36
Di Maso, Gennaro J...21501 Kelly, East Detroit
Dimond, Geo. E...18401 Bretton Dr., Detroit 23
Dionne, Paul E...12500 E. 12 Mile Rd., Warren
Dipiero, Raniero...1800 Tuxedo, Detroit 6
Dittmer, Edwin F...18342 Mack Ave., Detroit 36
Ditzler, John W...581 Rivard Blvd., Detroit 30
Dixon, Fredk. W...245 S. Martha, Dearborn
Dixon, Ray S. (L)...5001 Van Dyke, Detroit 13
Dodds, John C. (L)...30 Morand Rd., Detroit 36
Dodenhoff, Chas. F...18031 Kelly Rd., Detroit 24
Dodrill, Forest D...Woodberry Dr., Bloomfield Hills
Doering, Wendell R...17555 James Couzens, Detroit 35
Doig, Victor F...19676 Dale, Detroit 19
Dolan, Edward A...1960 Hammond Lake Dr., Pontiac
Dolega, Stanley F...15640 E. Warren Ave., Detroit 24
Dolgoff, Sidney...15600 Michigan Ave., Dearborn
Dolin, Simon...2900 S. Fort St., Detroit 17
Domzalski, Casimir A. (L)...5361 McDougall Ave., Detroit 11
Domzalski, Henry M...15252 Gratiot Ave., Detroit 5
Donald, Douglas (L)...7815 E. Jefferson Ave., Detroit 14
Donath, Rolf W...719 New Center Bldg., Detroit 2
Donovan, Eugene T...13349 Michigan Ave., Dearborn
Donovan, Richard S...17555 James Couzens, Detroit 35
Doran, John H...15101 Plymouth Rd., Detroit 27
Dorman, Jack...18245 Warrington Dr., Detroit 21
Dorsey, Edward C...8344 E. Jefferson, Detroit 14
Dorsey, John M...65 Moss Ave., Highland Park 3
Doty, Chester A. (L)...585 Robinson Dr., Prescott, Ariz.
Doub, Howard P. (L)...2799 W. Grand Blvd., Detroit 2
Dougherty, Edw. A., Jr...18241 W. McNichols Rd., Detroit 19
Douglas, Clair L. (L)...1201 Richmond St., London, Ontario, Canada
Douglass, Robt. C...23023 Orchard Lake Rd., Farmington
Dovitz, Benj. W...16820 Greenfield Ave., Detroit 35
Downer, Ira G. (L)...8445 E. Jefferson Ave., Detroit 14
Downes, Geo. O...15062 Houston, Detroit 5
Drake, Ellet H...Henry Ford Hospital, Detroit 2
Drake, James J. (R)...2820 Woodslee Dr., Royal Oak
Drapiza, Ruth L...22231 W. Outer Dr., Dearborn
Draves, Edward F...19647 Joy Rd., Detroit 28
Drazek, Jos. A...18980 Wyoming, Detroit 21
Drozdowska, Z. J. F...1413 Lafayette Twrs. W., Detroit
D'Sena Dorothy...33000 Palmer Rd., Wayne
Dubin, Jos. J...10401 W. Chicago Blvd., Detroit 4
Dubnove, Aaron (L)...2115 W. Grand Blvd., Detroit 8
Dubpernell, Martin S. (L)...4019 Gilbert St., Detroit 10
Dubpernell, Robt. O...18595 Grand River, Detroit 23
Dudek, John J...19244 Grand River, Detroit 23
Dumke, Paul R...2799 W. Grand Blvd., Detroit 2
Duncan, James R...550 Joy Rd., Detroit
Dundas, Edward M., Jr...4520 Firestone, Dearborn
Dunlap, Henry A...7815 Jefferson Ave. E., Detroit 14
Dunn, Cornelius E...3496 Burns, Detroit 14
Dupler, Gerald E...24234 Michigan Ave., Dearborn
Durham, Everett W...23100 Cherry Hill Rd., Dearborn 7
Durham, Robt...Henry Ford Hosp., Detroit 2
Dutcher, Dwight J...711 S. Oxford, Detroit 36
Duwe, Frank A...25321 Five Mile Rd., Detroit 39
Dwaihy, Paul J. (A)...14530 E. Warren, Detroit 15
Dwyer, Francis W...14440 W. McNichols, Detroit 35
Dyer, H. Lorne...44536 Chedworth, Northville
Dykema, Rosemary M...18424 Mack Ave., Detroit 36
Dziuba, John F...18901 W. Warren Ave., Detroit 28
Dzul, Paul...14620 E. Seven Mile Rd., Detroit 5
Eades, Chas C...19635 Mack Ave., Detroit 36
Eadie, Gordon A...16083 Southampton St., Livonia
Easterly, Robt. L...1404 Ford Ave., Wyandotte
Eaton, Crosby D. (L)...3011 W. Grand Blvd., Detroit 2
Echt, Raymond J...VA Hospital, Dearborn
Eckhous, Arthur W...1015 Kales Bldg., Detroit 26
Economy, Donald E...18 W. Lane Ct., Dearborn
Eder, Saml. J. (L)...19541 Cranbrook, Detroit
Edgar, Irving I...1036 David Whitney Bldg., Detroit 26
Edmonds, Gerald W...19795 St. Mary's Ave., Detroit 35
Edmonds, Wm. N. (L)...18525 Merriman Rd., Livonia
Edmondson, Robt. B...18501 Mack Ave., Detroit 36
Edwards, C. Rupert...Detroit Rec. Hosp., Detroit
Edwards, James G...17751 E. Warren Ave., Detroit 24
Egan, Charles F. (L)...Wyandotte Gen. Hosp., Wyandotte
Eisenbrey, A. B...Henry Ford Hosp., Detroit 2
Eisenstein, B...210 Professional Bldg., Detroit 1
Eisman, Clarence H. (L)...1121 Whittier Rd., Grosse Pointe 30
Eldredge, Edward F...18540 Mack Ave., Grosse Pointe 36
Elliott, Jos. P., Jr...Henry Ford Hospital, Detroit 2
Elliott, Robt. N...760 Fisher Bldg., Detroit 2
Ellis, Frank R...880 S. Lafayette, Dearborn 7
Elman, Meyer J...108 W. Hancock, Detroit
Elson, Abraham L...Lafayette Clinic, Detroit 7
Elvidge, Robt. J...2900 W. Grand Blvd., Detroit 2
Emmert, Herman C. (L)...4927 N. 34th, Arlington 7, Va.
Endler, Gerhard C...1394 Roslyn Rd., Grosse Pointe Woods
Enfroy, Henri L...19980 Shrewsburg, Detroit 21
Engel, Earl H...2336 Van Alstyne Blvd., Wyandotte
Engstrom, Fredk. W...2021 Monroe, Dearborn
Engstrom, Ruby M...1777 Culver Ave., Dearborn
Eno, Laurel S...212 Eastland Pr. Bldg., Detroit 36
Ensign, Dwight C...Henry Ford Hosp., Detroit
Eppler, Wm. R. (A)...Detroit Rec. Hosp., Detroit
Erickson, Eldon W...25750 W. Outer Dr., Lincoln Park
Erickson, Miles A...1932 Ford Ave., Wyandotte
Erman, Jos. M...19530 Stratford Rd., Detroit 21
Ermete, Sait D...32623 Cherry Hill, Garden City
Ernest, Reginald H...5050 Joy Rd., Detroit 4
Eschbach, Jos W...935 S. Military St., Dearborn
Esquejo-Capili, E...1347 Gault Dr., Ypsilanti
Eurs, Frank J...1340 Maccabees Bldg., Detroit 2
Evans, Gomer P., Jr...1553 Woodward Ave., Detroit 26
Evans, Jos. M...16431 Harper, Detroit 24

Ewing Chas. H..........17120 E. Warren, Detroit 24
Eyler, Wm. R..........2799 W. Grand Blvd., Detroit 2
Eyres, Alfred E..........17800 E. 8 Mile, Detroit 36

Fabok, Ferenc..........Northville St. Hosp., Northville
Fachnie, Harold L.....15800 W. McNichols Rd., Detroit 23
Faello, Sebastian J..........16840 E. Warren Ave., Detroit 24
Fagan, James P..........987 E. Jefferson, Detroit 7
Fagin, Irving D..........18254 Livernois Ave., Detroit 21
Fahim, Ramfis B..........14636 E. 7 Mile Rd., Detroit 36
Falick, Mordecai L..........3011 W. Grand Blvd., Detroit 2
Falk, Ira E..........17411 Cherrylawn, Detroit 21
Fallis, Lawrence S..........2799 W. Grand, Detroit 2
Fandrich, Theodore S. (R)..........200 Miramar Ave., Montecito, Calif.
Farbman, Aaron A..........14515 Kercheval, Detroit 15
Farina, Angel M..........23550 Joy Rd., Detroit 39
Farmer, Wm. L., Jr..........3335 W. Davison, Detroit 38
Farnam, Larry M., Jr..........19787 Mack Ave., Detroit 36
Faunce, Sherman P..........1824 Seminole St., Detroit 14
Fea, John F..........Mt. Carmel Mercy Hosp., Detroit 35
Feigelson, Howard H..........Sinai Hospital, Detroit 35
Feld, David..........15101 W. McNichols Rd., Detroit 35
Feldkamp, Lee E..........360 N. Main, Plymouth
Feldman, Irwin..........987 E. Jefferson Ave., Detroit 7
Feldman, Nathanial L.....24370 Tamarack Circle, Southfield
Feldman, Paul H..........16800 Greenfield, Detroit 35
Feldstein, Martin Z.....13345 W. McNichols Rd., Detroit 35
Fellner, Wm. A..........3202 Gen. Motors Bldg., Detroit 2
Fellows, William R..........3815 Pelham, Dearborn
Fenech, Harold B..........324 Professional Bldg., Detroit 1
Fenner, Wm. G..........12454 E. Outer Dr., Detroit 24
Fennessey, John F..........512 Rivard, Grosse Pointe 30
Fenton, Edwin H..........15125 Grand River Ave., Detroit 27
Fenton, Meryl M..........8600 W. McNichols Rd., Detroit 21
Fenton, Russell F..........15125 Grand River Ave., Detroit 27
Fenton, Stanley C..........No address
Fentress, Vance..........641 David Whitney Bldg., Detroit 26
Feringa, Philip J..........20901 Moross Rd., Detroit 36
Ferrara, Richard J...20045 Mack Ave., Grosse Pointe Woods
Ferrara, Virginia M..........18422 Woodward, Detroit 3
Ferris, George N..........20001 Greenfield, Detroit 35
Ferszt, Marion S..........15369 Grandville, Detroit 35
Figiel, Leo S..........1500 Balmoral, Grosse Pointe
Figiel, Steven J..........4160 John R St., Detroit 1
Filkin, Lawrence E..........621 Fairbrook, Northville
Fill, Leon..........987 E. Jefferson, Detroit 7
Finch, Alvis D..........18000 Jas. Couzens Hwy., Detroit 35
Finch, F. Sinclair..........894 N. Renaud, Detroit 36
Finck, Jerome H..........25841 Plymouth, Detroit 39
Fine, Edward..........1112 Kales Bldg., Detroit 26
Fine, Gerald..........Henry Ford Hosp., Detroit 2
Fink, Saml..........10161 Burton, Oak Park
Finkelstein, I. S..........17508 Dorset, Southfield
Finkelstein, Lionel..........199 W. Brown St., Birmingham
Finkelstein, M. B..........18254 Livernois, Detroit 21
Firestone, N. S..........10151 Michigan Ave., Dearborn
Firnschild, Paul G..........10538 Andrews, Allen Park
Fischer, Arthur J..........36016 Five Mile Rd., Livonia
Fischer, Fredk. J..........654 Fischer Bldg., Detroit
Fischhoff, Jos..........18674 Fairfield, Detroit 21
Fishbein, Herbert L..........987 E. Jefferson Ave., Detroit 7
Fisher, Geo. S..........1709 David Whitney Bldg., Detroit 26
Fisher, James M..........176 Merriweather, Grosse Pointe 36
Fisher, Ralph L..........8445 E. Jefferson Ave., Detroit 14
Fitzgerald, C. H..........Wayne Co. Gen. Hospital, Eloise
Fitzgerald, James M..........15801 W. McNichols, Detroit 35
Fitzpatrick, F. W..........17187 Schaefer, Detroit 35
Flaherty, Henry J..........19600 W. McNichols Rd., Detroit 19
Flaherty, Norman W..........24315 Fairmont Dr., Dearborn
Flake, Thomas M..........5050 Joy Rd., Detroit 4
Flora, Wm. R..........8100 E. Jefferson Ave., Detroit 14
Flower, James A. (R)..........3230 Sunset Dr., Fallbrook, Calif.
Floyd, William S..........19105 W. Seven Mile Rd., Detroit 19
Fogt, Herbert E. (L)..........16829 Harper Ave., Detroit 24
Fogt, Robt. G..........16829 Harper Ave., Detroit 24
Foley, Hugh S. (L)..........23100 Cherryhill, Dearborn
Foote, John A..........1336 Southfield Road, Lincoln Park
Ford, Geo. A. (L)..........28 W. Adams Ave., Detroit 26
Fordell, Frank S..........22159 W. Outer Dr., Dearborn
Forgrave, Edward G..........18520 Grand River, Detroit 23
Forrer, Gordon R..........20141 James Couzens, Detroit 35
Fosnaugh, Robert P..........23185 Timberline, Southfield
Foster, E. Bruce..........20905 Greenfield Rd., Southfield
Foster, Owen C. (L)..........1553 Woodward Ave., Detroit 26
Foster, Wallace M..........13700 Woodward Ave., Highland Park 3
Fowler, Melvin E..........247 E. Warren St., Detroit 1
Fraiberg, Paul L..........12950 W. Chicago Blvd., Detroit 28
Frame, Boy..........18694 Warrington Dr., Detroit 21
France, Chas. J..........838 Berkshire Rd., Grosse Pointe 30
Franjac, Marion J..........25447 Plymouth Rd., Detroit 39
Franklin, John E..........4075 Ink Rd., Inkster
Franklin, Philip R. (A)..........Detroit Receiving Hosp., Detroit
Franzen, Nils A..........19566 W. Grand River, Detroit 23
Frazer, Mary M. (L)..........748 Seminole, Detroit 14
Frederickson, Geo. C..........7430 Second, Detroit 2
Free, Harry W..........14300 W. McNichols, Detroit 35
Freedman, Arthur M..........7701 Wyoming, Dearborn
Freedman, John (R)..........4853 Second Blvd., Detroit 1
Freeman, Donald K..........881 Chalmers St., Detroit 15
Freeman, Mable..........1316 David Broderick Twr., Detroit 26
Freeman, Michael W..........1810 Wellesley Dr., Detroit 3
Freeman, Wilmer..........940 East 7 Mile Rd., Detroit 3
Freid, Samuel..........17537 Parkside, Detroit 21
Freier, Andrew A..........19321 Greenfield, Detroit 35
Freier, Morton L..........13051 Puritan Ave., Detroit 27
Freilich, Olga..........Crittenton General Hospital, Detroit
Freitas, Eugene L..........St. John's Hospital, Detroit 36
Fremont, J. Courtney (A)..55 Hall Place, Grosse Pte. Frms.
Frey, James L..........1553 Woodward Ave., Detroit 26
Friedlaender, Alex S..........10300 W. Seven Mile Rd., Detroit 21
Friedlaender, Sidney..10300 W. Seven Mile Rd., Detroit 21
Friedlander, Joseph (A)..........3776 Leslie, Detroit 38
Friedman, David..........2429 E. Milwaukee Ave., Detroit 11
Friedman, Isidor H..........3773 2nd Ave., Detroit 1
Friedman, Seymour..........5132 Allen Rd., Allen Park
Frisch, Emanuel..........1800 Tuxedo, Detroit 6
Frost, Harold M..........Henry Ford Hosp., Detroit 2
Frost, Richard G..........1800 Tuxedo, Detroit 6
Fryfogle, James D..........Cd. 8, Med. Concourse, Northland Center, Southfield
Fulgenzi, William R..........1305 Kales Bldg., Detroit 26
Fuller, Hugh M..........1257 David Whitney Bldg., Detroit 26
Fulton, Wm. J. (R)..........Wye Ferry, Queenstown, Md.
Gaffney, J. Mitchell..........13600 Ohio, Detroit 21
Gagliardi, Carl A..........3516 Fort St., Lincoln Park
Gahagan, Thomas..........Henry Ford Hospital, Detroit 2
Gajewski, John E..........Parke Davis and Co., Detroit 32
Galacz, Robert J..........10703 Santa Maria, Detroit
Galantowicz, H. C..........7433 Mich. Ave., Detroit 10
Galantowicz, Thos. H..........23601 Ford Rd., Dearborn
Galdonyi, Laslo (L)..........2311 Dav. Broderick Twr., Detroit 26
Galdonyi, Nicholas (L)....8106 W. Jefferson Ave., Detroit 17
Galerneau, Darrel B. (L)..........7394 Engleman, Centerline
Gall, Henry..........275 W. Grand Blvd., Detroit 16
Gallant, Vincent J..........16766 Ashton, Detroit 19
Galvin, Paul P..........14440 W. McNichols Rd., Detroit
Ganos, Thos..........6742 Park Ave., Allen Park
Gans, Robert I..........7310 W. Seven Mile Rd., Detroit 21
Ganschow, John H..........1840 Holbrook Ave., Detroit 12
Gardner, Lawrence W..........6071 W. Outer Dr., Detroit 35
Gardner, Max L..........19557 Mack Ave., Grosse Pointe
Gariepy, Louis B..........16401 Grand River St., Detroit 27
Gariepy, Louis J. (L)..........16401 Grand River, Detroit 27
Gass, H. Harvey..........529 Fisher Bldg., Detroit 2
Gaston, Herbert B..........7501 W. Morrow Circle, Dearborn
Gates, Nathaniel (L)..........516 Professional Bldg., Detroit 1
Gaynor, Alex..........1755 E. 7 Mile Rd., Detroit 3
Gehring, Harold W..........20211 Greenfield, Detroit 35
Geib, Ledru O. (L)..........3528 Van Dyke Ave., Detroit 14
Geitz, Wm. A. (R)..........Box 1133, Boca Raton, Fla.
Gelbach, Philip D..........2900 S. Fort St., Detroit 17
Gerisch, Robt. A..........1217 Dav. Whitney Bldg., Detroit 26
Gerondale, Elmond J. (L)..........3001 W. Grand Blvd., Detroit 2
Gibson, Dunbar P..........Box 1256, Detroit 31
Gibson, Wm..........7440 Mack Ave., Detroit 14
Giese, Fred W..........18526 Schoolcraft, Detroit 23
Gigante, Nicola (L)..........10 Peterboro, Detroit 1
Gigliotti, David..........16001 9 Mile Rd., Southfield

Gilbert, Harold R.........................13146 Phelps, Wyandotte
Giles, Conrad L.........407 Northland Med. Bldg., Southfield
Gillespie, Stephen M.............23100 Cherry Hill, Dearborn
Gilpin, Watson A.............1539 Lockridge, Bloomfield Hills
Gilreath, James L.............................1800 Tuxedo, Detroit 6
Gilroy, John.............................John Harper Hospital, Detroit
Gimbel, Nicholas S.........................1800 Tuxedo, Detroit 6
Ginsberg, Harold I..........15344 McNichols Rd., Detroit 35
Girnius, Birute...................................15439 Harper, Detroit 24
Gitlin, Chas..........................2424 Oakman Blvd., Detroit 35
Gittins, Perry C.................20905 Greenfield Rd., Southfield
Givens, Donovan H..........3453 Charlevoix Ave., Detroit 7
Givens, Donovan H., Jr.............9041 Dexter Blvd., Detroit
Gizynski, Waldemar E...............15400 Edington Rd., Livonia
Glasgow, Gordon K. (R)..1174 3 Mile Rd., Grosse Pointe 30
Glassman, Saml. (L)....10185 Collins Ave., Bal Harbour, Fla.
Glazer, Walter S.............1490 Charrington Rd., Birmingham
Glees, John L..................................Chrysler Corp., Centerline
Glemet, Raymond B. (L).....................216 W. Grand Blvd., Detroit 16
Glikman, Victor................20131 James Couzens, Detroit 35
Glowacki, Ben F.................8 Mile & Greenfield, Southfield
Glowacki, Edward T..........................P.O. Box 5195, Detroit
Glowacki, Raymond M.......................961 Monroe, Dearborn
Godley, Alegro J.............................8401 Woodward, Detroit
Goerke, Elmer A.....................36663 Goddard Rd., Romulus
Goetz, Angus G.................1553 Woodward Ave., Detroit 26
Goins, Wm. F.................................6675 Tireman, Detroit 4
Goldberg, Arthur............340 E. Eight Mile Rd., Detroit 3
Goldberg, Harry H. (L)....................2211 Woodward Ave., Detroit 1
Goldberg, Nathan H. (L)................2211 Woodward Ave., Detroit 1
Golden, Alfred............26764 York Rd., Huntington Woods
Goldfaden, Alfred....................9122 W. Fort St., Detroit 9
Goldman, Aubrey.........17191 James Couzens, Detroit 35
Goldman, Perry.........................16805 Princeton, Detroit 21
Goldman, Robert T.............Wayne County Hospital, Eloise
Goldrath, Milton H.........17000 W. 8 Mile Rd., Southfield
Goldstein, Abe S.............18450 North Lawn, Detroit 21
Goldstein, Sidney (A)....................Northville State Hosp., Northville
Gollman, Maurice D.....................17000 W. Eight Mile Rd., Southfield
Gomley, Romuald H.............7220 Gratiot Ave., Detroit 13
Goodman, Maxwell M.........22265 Garrison, West Dearborn
Goodman, Virgil P.........762 Bedford Rd., Grosse Pte. Pk.
Goodwin, Warren W.........20131 James Couzens, Detroit 35
Goodwin, William P.................1616 Boston W., Detroit 6
Gordon, John W. (R)............15123 Artesian Ave., Detroit
Gordon, Wm. E.....................18058 Greenfield, Detroit 35
Gorelick, Martin J.............23901 Michigan Ave., Dearborn
Gorning, Raymond P.....................857 Marlborough Ave., Detroit 15
Goryl, Stephen V.........................21501 Kelly, East Detroit
Goss, Samuel B...................................10 Peterboro, Detroit 1
Gotham, James E..........................3825 Brush St., Detroit 1
Gottlieb, Jacques S.................951 E. Lafayette, Detroit 7
Goux, Raymond S. (L).........................545D Whitney Bldg., Detroit 26
Grabiel, Amado........................10151 Michigan, Dearborn
Grace, Jos. M.........27453 Rainbow Circle, Lathrup Village
Grady, Jos. A......................946 Three Mile Dr., Detroit 30
Graham, John G., Jr.................................491 Lincoln Rd., Grosse Pointe 30
Graham, Theodore N.....................2424 Puritan, Detroit 38
Granger, Francis L.............14160 Gratiot Ave., Detroit 5
Granger, George R.....................705 David Whitney Bldg., Detroit 26
Grant, Abraham H...........22454 Chatsford Circle, Southfield
Grant, Heman E. (L)...Lewiston
Gratton, Henri L. (L).........76 W. Adams Ave., Detroit 26
Graves, James H...........................861 Fisher Bldg., Detroit 2
Gray, Howard O.................................5050 Joy Rd., Detroit
Greek, Louis M.................12901 E. McNichols, Detroit 5
Green, Edward W.............2799 W. Grand Blvd., Detroit 2
Green, Ellis R. (L)............5172 Scotten Ave., Detroit 10
Green, Henry L.............................24260 Dante, Oak Park
Green, Lewis.......................13000 Grand River, Detroit 27
Green, Milton M.............1180 Southfield Plaza, Southfield
Green, Nelson W.............31815 Southfield Rd., Birmingham
Green, Thomas, Jr.............................5050 Joy Rd., Detroit 4
Greenberg, Jack R.........15743 W. 7 Mile Rd., Detroit 35
Greenberg, Julius J.............5328 W. Outer Dr., Detroit 35
Greenberg, Morris Z.......................9105 Van Dyke, Detroit 13
Greenberg, Stanley.................20905 Greenfield, Southfield
Greene, John B.............2179 W. Grand Blvd., Detroit 8
Greene, Thomas J..........................2425 W. Boston, Detroit 6
Greenidge, Robt. I. (L)............4839 Beaubien, Detroit 1
Greenlee, Wm. T. (L)............15053 Maddelein, Detroit 5
Greenslit, Frank S..........U.S. Vets. Admin. Hosp., Dearborn
Gregory, Louis J.................47 Webber Place, Detroit 36
Greiner, Bert A.............14607 E. Seven Mile Rd., Detroit 5
Grekin, John N.............7421 W. Seven Mile Rd., Detroit 21
Grier, William H.................1575 E. Lafayette, Detroit 7
Griffin, Robert J.................17401 Mack Ave., Detroit 24
Griffiths, Sydney J.............15400 Plymouth Rd., Detroit 27
Grimaldi, Gregory J. (A)............2983 Seminole, Detroit 14
Grinstein, Alexander..................18466 Wildemere, Detroit 21
Grishkoff, M. A..........................2201 E. Jefferson, Detroit 7
Griva-Lizlovs, S.................29901 Ford Rd., Garden City
Grob, Otto (A)............515 E. Sola, Santa Barbara, Calif.
Gronemeyer, Wm. H.....................1800 Tuxedo, Detroit 6
Grossman, Solomon C.....................26339 Woodward Ave., Huntington Woods
Gudes, David S.........................1080 Fisher Bldg., Detroit 2
Guerrero, Jose............................13700 Woodward, Detroit 3
Guidot, Julian M.............13345 W. McNichols, Detroit 35
Guimaraes, Abilio S. (L).....................7301 Schaffer Hwy., Dearborn
Guinan, Geo. E.....................27614 Gainsborough, Inkster
Guindi, Mounir F...........21261 Ridgedale Dr., Oak Park 37
Guindi, Sami F.....................1080 Fisher Bldg., Detroit 2
Gulick, Arthur E..........................4160 John R, Detroit 1
Gurdjian, Elisha S.........1553 Woodward Ave., Detroit 26
Gurskis, Eugenia E.................504 Kales Bldg., Detroit 26
Gustafson, David C.....................4171 Seminole, Royal Oak
Gutow, Benjamin R...................................20867 Mack, Detroit
Guyton, Jack S.................2799 W. Grand Blvd., Detroit 2
Hacker, Elaine M.............................293 Merriweather Rd., Grosse Pointe Farms
Hackert, John L.............14551 Southfield Rd., Allen Park
Haddad, Benjamin F.................1010 Mich. Mutual Bldg., Detroit 26
Haddad, Elias D..........................17830 E. Warren, Detroit
Hadesman, Donald....................985 E. Jefferson, Detroit 7
Hadjimihaloglu, B. S.............2429 E. Milwaukee, Detroit 11
Haefele, Leslie P.................29108 Ford Rd., Garden City
Hagermoser, H. H. (A)............6126 Yorkshire, Detroit 24
Hagge, Donald R.........29594 W. Five Mile Rd., Livonia
Haidostian, B. H.............18456 Grand River, Detroit 23
Haines, Ellen R...525 Seyburn, Detroit
Haitinger, K. S.............................22175 Thorofare, Grosse Ile
Haking, Leonard................14014 E. 7 Mile Rd., Detroit 5
Halekas, G. Peter........21727 Mack Ave., St. Clair Shores
Hall, Arch H...10 Peterboro, Detroit 1
Hall, E. Walter (L).........14189 Rosemont Rd., Detroit 23
Hall, Ralph E. (L).....................10 Peterboro St., Detroit 1
Hall, Richard H............................828 Fisher Bldg., Detroit 2
Hall, Winthrop D..................5237 Oakman Blvd., Dearborn
Hallen, Leonard J.............................1335 Nicolet Pl., Detroit 7
Hamburg, Robt. H.........1515 Dav. Whitney Bldg., Detroit
Hamburger, Albert C.............13345 W. McNichols, Detroit
Hamburger, Stuart W.......18400 Schaefer Hwy., Detroit 35
Hamil, Brenton M.............Henry Ford Hosp., Detroit 2
Hammer, Edwin J.................16616 Mack Ave., Detroit 24
Hammer, Roy W.............11455 E. McNichols, Detroit 35
Hammond, Arthur E.........1553 Woodward Ave., Detroit 26
Hammond, James L. (L)....1006 Morse St., Oceanside, Cal.
Handel, Jack E............................1800 Tuxedo, Detroit 6
Hank, Emil J.......................32316 Grand River, Farmington
Hansen, Fredk. E. (L)....................................18160 Birwood, W. Beverly Hills, Birmingham
Hansen, John W. (R).....................8877 Perrin Dr., Livonia
Hanyi, Karl..................................7645 Thornwood, Plymouth
Hardstaff, R. John (L)............648 Neff Rd., Grosse Pte. 30
Hardt, Barbara A. (A)........15867 Mansfield, Detroit 27
Hardy, Clarence M.........................23019 Ecorse Rd., Taylor
Hardy, Geraldine M...........................18145 Mack, Detroit 24
Hardy, Warren G.........801 Dav. Whitney Bldg., Detroit 26

Harelik, Ely W.........Detroit House of Correction, Plymouth
Harkaway, Roman W.............19125 Van Dyke, Detroit 34
Harley, Garth H.....................451 Golfcrest Dr., Dearborn
Harley, Louis M.........4100 W. McNichols Rd., Detroit 21
Harm, Winfred B. (L)................16260 Cherrylawn Ave., Detroit 21
Harmon, Edwin L.......................441 E. Jefferson, Detroit 26
Harmon, Walter, Jr.............2510 E. Davison, Detroit 12
Harnett, R. W. F........................529 Fisher Bldg., Detroit 2
Harper, Jesse T.........1252 Dav. Whitney Bldg., Detroit 26
Harrell, Voss (A)............1035 Oakwood Ave., Dearborn 7
Harrington, Edw. B.............14853 Michigan Ave., Dearborn
Harrington, F. L.............14044 W. McNichols, Detroit 35
Harris, A. D................................12815 Linwood, Detroit 38
Harris, Donald (A)........................490 Griswold, Northville
Harris, Harcourt G.............9141 Dexter Blvd., Detroit 6
Harris, Harold H.....................8011 W. Vernor Highway, Detroit 9
Harris, Ivor D............................1245 David Whitney Bldg., Detroit 26
Harrity, William A.....302 Eastland Prof. Bldg., Detroit 36
Hart, Charles E.....................23845 Van Dyke, Centerline
Hart, John C................................9341 Moffat, Detroit 13
Hart, Zwi H......................Plymouth State Home, Northville
Hartkop, Henry H.............20055 Mack Ave., Detroit 36
Hartquist, Robt. J.........................1495 Fort St., Wyandotte
Hartzell, John B.........7815 Jefferson Ave. E., Detroit 14
Hartzell, John M.....................7815 E. Jefferson, Detroit 15
Hasley, Clyde K. (L)......................2320 N. LaSalle Gardens, Detroit 6
Hasley, Danl. E. (R)............16512 Shaftsburg, Detroit 19
Hassett, Gerald R.........................St. Marys Hospital, Livonia
Hassig, Walter W.....................20914 Kelly, East Detroit
Hastings, Orville J.............15744 Harper Ave, Detroit 24
Haszczyc, Vladimir A.....................3329 Yemana, Detroit 7
Hathaway, Hubert R. (A)................154 Englewood Rd., Springfield, Ohio
Haubrich, Wm. S.................Henry Ford Hosp., Detroit 2
Hause, Glen E.................18520 Grand River, Detroit 23
Hauser, I. Jerome....................7411 Third Ave., Detroit 2
Hauser, John E.........................405 Northland Med. Bldg., Southfield
Hauser, Maurice J. (A)........7411 Third Ave., Detroit 2
Havers, Howard (L)............271 Kenwood Ct., Detroit 36
Hawkins, James W. (L)....................3885 Prudence Drive, Sarasota, Fla.
Hayden, Royal C., Jr.........................Henry Ford Hospital, Detroit 2
Hayes, Allen L.............................19207 Schaefer, Detroit 35
Hazen, Roy S.........20526 Grand River Ave., Detroit 19
Heath, Leonard P.............1553 Woodward Ave., Detroit 26
Heavner, Lyle E.................119 Kercheval, Grosse Pointe 36
Hecht, Manes S.............26711 Woodward, Huntington Wds.
Heenan, Theophilus H.....................1553 Woodward Ave., Detroit 26
Heideman, Louis E.............20211 Greenfield Rd., Detroit 35
Heil, Edward R.....................19190 Greenfield, Detroit 35
Heins, Marilyn........................747 Lakeland, Grosse Pte. 30
Heldt, Richard F.................1951 Monroe Blvd., Dearborn
Heldt, Thos. J. (L)..............17 Poplar Park, Pleasant Ridge
Helman, Norman........15001 W. Eight Mile Rd., Detroit 35
Hendelman, Manuel H.................17141 Hayes, Detroit 5
Henderson, Allison B.........9041 Dexter Blvd., Detroit 6
Henderson, Arthur B. (L)....................10452 Mack Ave., Detroit 14
Henderson, Chas. W.........20905 Greenfield Rd., Southfield
Henderson, Frederic C.............18101 E. Warren, Detroit 24
Henderson, Harold (L)....................20905 Greenfield Rd., Southfield
Henderson, Hugh W.............18101 E. Warren, Detroit 24
Henderson, Leslie T. (L)........14814 E. Warren, Detroit 15
Henderson, Wm. E. (L)........18101 E. Warren, Detroit 24
Hendria, Alan K.........................15540 Harper, Detroit 24
Henig, Fred N.........7605 W. Seven Mile Rd., Detroit 21
Henkin, Raymond........................17228 Shervilla, Southfield
Henkin, Wm. A.....................18215 Greenfield, Detroit 35
Hennes, Allen R............................Wayne St. Univ., Detroit
Hennessey, Alan T.....................Grace Hospital, Detroit 35
Henrich, Laurence E...........2501 W. Grand Blvd., Detroit 8
Henry, Robert C.........................1 Layfayette Pl., Detroit 21
Herbst, Harold B.............7282 Riverstone Rd., Birmingham
Hergt, Klaus....................30320 Pondsview Dr., Franklin

Herrero, Eduardo M..............................9215 Prevost, Detroit
Herrero, Eduardo U..............................9215 Prevost, Detroit
Herrold, Rose E.............1277 E. Grand Blvd., Detroit 11
Herschelmann, Roy F.........3343 Gratiot Ave., Detroit 7
Hershey, Ernest A., Jr.........307 Dav. Whitney Bldg., Detroit
Hertzler, Jack H.............3011 W. Grand Blvd., Detroit 2
Herwick, John T.............2799 W. Grand Blvd., Detroit 2
Hess, Joseph W.............................Harper Hospital, Detroit 1
Hess, Murray W................................30650 Bruce, Franklin
Hessburg, Philip C.................Henry Ford Hospital, Detroit 2
Heyman, Louis F.........................19009 W. Seven Mile Rd., Detroit 19
Heyner, C. S.................28 W. Adams Avenue, Detroit 26
Heyner, Stanley A.............3424 Oakman Blvd., Detroit 4
Hickey, Jos........................23100 Cherry Hill, Dearborn
Hicks, Fredk. G..........................1000 Westwood, Birmingham
Higuera, J. Gilberto........13700 Woodward Ave., Detroit 3
Hildner, Frank J. (A)............16840 Monica, Detroit 21
Hill, Edward J., Jr.......208 David Whitney Bldg., Detroit 26
Hill, Raymond D.................14551 Southfield, Allen Park
Hill, Welford T.............................6303 Mack Ave., Detroit
Hillenberg, Sidney J.........19350 W. 7 Mile Rd., Detroit 19
Hiller, Glenn I.............13700 Woodward Ave., Detroit 3
Hillyer, John W.............26151 Huron River Dr., Flat Rock
Hilton, Wm. E. (L)....................5013 Harding, Detroit 13
Hinchman, D. F.......................27459 Five Mile Rd., Livonia
Hipps, Chauncey J.........2605 West Grand Blvd., Detroit 8
Hirsch, Leo J.....................15800 W. McNichols, Detroit 35
Hirsch, Lore................................212 S. Melborn, Dearborn
Hirschfeld, A. H.....................829 Fisher Bldg., Detroit 2
Hoagland, F. L. (A)...No address
Hobbs, Donald V................................27305 Southfield Rd., Lathrup Village
Hochman, Morton M.........16633 Plymouth Rd., Detroit 27
Hodges, Jason....................26401 Harper, St. Clair Shores
Hodgkinson, Chas. P....................17546 Meadwood Ave., Lathrup Village
Hoffer, Thos.............................5825 Allen Rd., Allen Park
Hoffman, Ben G.......................19545 Shrewsbury, Detroit 21
Hoffman, Edward A.....................7615 W. Vernor Hwy., Detroit 9
Hoffman, Edwin S. (R)....................8106 E. Jefferson Ave., Detroit 14
Hoffman, Harry Y.........................15085 E. Seven Mile Rd., Detroit 5
Hoffman, Henry A.........10015 E. Outer Dr., Detroit 24
Hoffman, Louis............18203 Birchcrest Dr., Detroit 21
Hoffman, Milton C.................18555 E. Warren, Detroit 36
Hogikyan, Azat........16901 W. McNichols Rd., Detroit 35
Holdredge, Jean M.............3011 W. Grand Blvd., Detroit 2
Hollander, Abraham J.....................14327 Michigan Ave., Dearborn 2
Hollinger, F. Wayne........8265 Gen. Mtrs. Bldg., Detroit 2
Hollis, Henry B.............................6809 Sirena, Detroit 10
Holloway, Horace R.............12840 Linwood, Detroit 38
Holloway, Janet L.........................7430 Second, Detroit 2
Holmes, Geo. F.................14729 Champaign, Allen Park
Holstein, Arthur P.............716 Anita Ave., Grosse Pte. Wds.
Holt, Chas. J., Jr...................1210 S. Oxford, Grosse Pte. 30
Holt, Henry T.............................5050 Cass St., Detroit 2
Homeister, Eugene A.....................12925 Pennsylvania Ave., Wyandotte
Honhart, Fred L. (L)............................1405 Berkshire Road, Grosse Pointe 30
Hopkins, Andrew J...........................4407 Roemer, Dearborn
Hopkins, George C...........................3183 Mack, Detroit 7
Hopkins, Scovell M.........910 Dav. Broderick Twr., Detroit
Hopkins, Wm. F.............................426 W. Hewitt, Marquette
Horkins, Earl J.................10963 Farmington Rd., Livonia
Horn, Robt. C., Jr.................2799 W. Grand Blvd., Detroit 2
Hornbeck, Robert J.........31500 Schoolcraft Rd., Livonia
Horny, Hugo O.................619 Barrington Rd., Detroit 30
Harrell, Eugene D.....................1408 Kales Bldg., Detroit 26
Horton, Reece H.........606 Northland Med. Ctr., Southfield
Horvath, James J.............1553 Woodward Ave., Detroit 26
Horvitz, Victor S.................18400 Schaefer Hwy., Detroit 35
Hotchkiss, Loris M.....................33220 W. 7 Mile, Livonia
Howard, Philip J.................Henry Ford Hosp., Detroit 2
Howard, William K.....................1800 Tuxedo, Detroit 6
Howell, Bert F.................10800 Whittier Rd., Detroit 24
Howell, James T.................2799 W. Grand Blvd.. Detroit 2

Howes, Homer A.........1515 Dav. Whitney Bldg., Detroit 26
Howlett, Howard T.........868 Fisher Bldg., Detroit 2
Hoyos, Pedro G.........6085 Campus Dr., Dearborn Hts.
Hoyt, Charles N.........5475 Woodward Ave., Detroit 2
H'Romadko, Louis (L).........1075 Fisher Bldg., Detroit 2
Hubbard, John P., Jr.....14620 E. Seven Mile Rd., Detroit 5
Huber, Philip J.........1724 Bassett, Royal Oak
Hudson, J. Stewart (L).........17443 E. Jefferson Ave., Grosse Pointe 30
Hudson, Wm. A. (L).........502 S. Pine St., Harrison, Ark.
Hudspeth, E. Rae.........753 Fisher Bldg., Detroit 2
Huebl, Hubert C.........Detroit Receiving Hosp., Detroit
Huegli, Wilfred A.........16840 E. Warren Ave., Detroit 24
Huggins, H. Horne.........8355 Gratiot, Detroit 13
Hughes, Calvin H.........19959 Vernier, Harper Woods
Hughett, Arthur J.........19959 Vernier, Harper Woods
Hulick, Archie G.........1600 Tuxedo, Detroit
Hull, Leroy W. (L).........6364 Cowell Rd., Brighton
Hullerman, Hugo V.........Childrens Hospital, Detroit 2
Hume, H. Ross, Jr.........1553 Woodward, Detroit 26
Huminski, Thaddeus S.........19244 Van Dyke Ave., Detroit 34
Hummel, Arthur R.........1020 3 Mile Dr., Grosse Pointe 30
Hunt, Theodore H.........19431 Van Dyke Ave., Detroit 34
Hunt, Verne G.........1553 Woodward Ave., Detroit 26
Hunter, Donald G.........3245 E. Jefferson, Detroit 17
Hunter, Robert B.........Henry Ford Hosp., Detroit 2
Husband, Chas. W. (L).........14500 W. McNichols, Detroit
Husband, Raymond C.........14500 W. McNichols, Detroit 35
Hutchins, M. Colton.........3011 W. Grand Blvd., Detroit 2
Hyatt, Jarvis M.........22340 Michigan Ave., Dearborn
Hyde, Fredk. W., Jr.........Grace Hospital, Detroit 1
Hyland, John R.........17200 Mack, Detroit 24
Hysni, Aliqemal.........8031 W. Vernor Hwy., Detroit 9
Iacobell, Peter H.........19300 Van Dyke, Detroit 34
Iacobellis, M.........22159 W. Outer Drive, Dearborn
Iglesias, Luis J.........20211 Greenfield, Detroit 35
Igna, Eli J.........2799 W. Grand Blvd., Detroit 2
Ignagni, Antonio.........21470 Sloan Dr., Detroit 16
Indenbaum, Samuel.........18400 Schaefer Hwy., Detroit 35
Ine, Myung Yul.........1800 Tuxedo, Detroit 6
Ingberg, Harry O.........261 Brady, Detroit 1
Irvin, Earle A.........Ford Motor Co. American Rd., Dearborn
Irwin, Wm. A.........16001 9 Mile Rd., Southfield
Isaacson, Arthur (L).........18989 San Juan, Detroit 21
Isaacson, Harold E.........15361 Plymouth Rd., Detroit
Isaacson, Jo D.........26008 Pembroke, Huntington Wds.
Israel, Barney B.........663 Fisher Bldg., Detroit 2
Israel, Kenneth.........10607 W. 7 Mile Rd., Detroit 21
Itkin, H. David.........2900 S. Fort St., Detroit 17
Iwata, Herbert T.........7611 Patton Ave., Detroit 28
Izner, Bernice,.........18050 Fairway Dr., Detroit 21
Izner, Sanford M.........17500 Schaefer Hwy., Detroit 35
Jacknow, David.........60 W. Hancock, Detroit 1
Jackson, Franklin R. (A)....Detroit Receiving Hosp., Detroit
Jackson, Winston B.........2425 Oakman, Detroit 38
Jacobs, Howard.........18241 Greenfield, Detroit 35
Jacobson, Lyle F.........5224 St. Antoine, Detroit 2
Jacobson, Saml. D.........Wayne Co. Genl. Hosp., Eloise
Jacobus, Wayne N.........20055 Mack Ave., Grosse Pte. 36
Jaeger, Grove A.........11711 Minden, Detroit 5
Jaekel, Clarence N. (L).........1086 E. Grand Blvd., Detroit 7
Jaffar, Donald J.........671 Fisher Building, Detroit
Jaffe, Harold W.........1706 David Whitney Bldg., Detroit 26
Jaffe, Jacob.........2211 Woodward Ave., Detroit 1
Jaffe, Julius L.........7465 Harper Ave., Detroit 13
Jaffe, Louis.........18662 Muirland, Detroit 21
Jahsman, Wm. E. (R).........1410 Sunset Dr., Clearwater, Fla.
Jakacki, Richard Wm.........36157 Sherwood, Livonia
Jakobovits, Thomas.........15361 Plymouth, Detroit 27
Jakoff, Jacques.........No address
James, Thomas N.........Henry Ford Hosp., Detroit 2
Jamieson, Thos. J.........1447 S. Indian Summer, West Covina, Calif.
Janicki, Natalia J.........Eloise Hosp., Eloise
Jarre, Hans A. (L).........Grace Hospital, Detroit 1
Jarvis, Harold F.........360 Moross, Detroit 36
Jasion, Lawrence J. (A).........11945 Payton, Detroit 24
Jaslow, Robt. I.........Plymouth St. Trng. Sch., Northville

Jaynes, Richard V.........29901 Ford Rd., Garden City
Jeffries, Benj.........19959 Vernier Rd., Harper Woods
Jend, Wm., Jr.........1365 Cass Ave., Detroit 26
Jend, Wm. J. (L).........12781 E. Outer Dr., Detroit 24
Jenkins, Elwood A.........610 Dav. Whitney Bldg.,Detroit 26
Jennings, Chas. G.........17700 Mack Ave., Detroit 24
Jensen, Viggo W.........532 Lincoln Rd., Detroit 30
Jevons, William H.........8425 Twelve Mile Rd., Warren
Jewell, F. C.........7220 Gratiot Ave., Detroit
Jewell, John S.........2021 Monroe, Suite 203, Dearborn
Jewell, Marvin R.........Childrens Hospital, Detroit 2
Jocz, Marion W.........945 Trombley Rd., Detroit 30
Jodar, Emery O.........15760 Mack Ave., Detroit 24
Jodar, Loyal W.........18412 Mack, Grosse Pointe 36
John, Hubert R. (L).........20905 Greenfield, Southfield
Johnson, Aran S.....642 Blairmoor Ct., Grosse Pte. Wds. 30
Johnson, Arthur J.........Henry Ford Hospital, Detroit 2
Johnson, Gage (A).........2785 S. Ford St., Detroit 27
Johnson, Homer L.........2799 W. Grand Blvd., Detroit 2
Johnson, Simon O.........Cadillac Sq. Bldg., Detroit 26
Johnson, Thos. D.........18530 Grand River, Detroit 23
Johnson, Verne E.........2051 Monroe Ave., Dearborn
Johnson, Vernon P.........21327 Harper Ave. St. Clair Shores
Johnson, Wilbur E.........14654 Gratiot, Detroit 5
Johnson, Wm. H. M. (L).........7157-63 Michigan, Detroit 10
Johnston, Everett V. (L)....30130 Bristol Lane, Birmingham
Johnston, Herbert C.........3001 Miller Rd., Dearborn
Johnston, Jos. A.........Henry Ford Hosp., Detroit 2
Johnston, Peter J.........Henry Ford Hosp., Detroit 2
Johnston, Wm. E. (L).........3011 W. Grand Blvd., Detroit 2
Johnstone, Benj. I.........555 Fisher Bldg., Detroit 2
Joinville, Euclide V. (L).........1202 Stroh Bldg., Detroit 26
Jones, Adrian R. (L).........15309 Mack Ave., Detroit 24
Jones, Arnold M.........3706 Sturtevant, Detroit 6
Jones, G. Richard.........18412 Mack Ave., Detroit 36
Jones, Roy D.........10234 Puritan Ave., Detroit 38
Jones, Wm. J.........8209 Allen Rd., Allen Park
Joos, Thad H.........20867 Mack, Grosse Pte. Woods
Jordan, Prescott, Jr.........5224 St. Antoine, Detroit 2
Jordan, R. Gerald.........12410 Van Dyke, Detroit 34
Joseph, Ramon R.........Wayne Co. Gen. Hospital, Eloise
Joyce, Stanley J.........1078 Fisher Bldg., Detroit 2
Joyrich, Myron H.........Sinai Hospital, Detroit 35
Juliar, Benj.........17305 Muirland Ave., Detroit 21
Jungwirth, R. V.........19350 W. McNichols Rd., Detroit 19

Kackley, James E.........18495 Mack, Detroit 36
Kain, Thomas R.........1400 Chrysler Exp. Way, Detroit 7
Kaine, Henry D.........3011 W. Grand Blvd., Detroit 2
Kalayjian, Bernard S.........30676 Harlincin Ct., Franklin
Kalichman, Nathan.........19304 Wyoming, Detroit 21
Kallenbach, Rudolf W.........388 Inkster Rd., Inkster
Kallet, Herbert I. (L).........651 Fisher Bldg., Detroit 2
Kallet, Maerit B.........1800 Tuxedo, Detroit 6
Kallman, David (L).........2351 W. Grand Blvd., Detroit 8
Kallman, Leo.........2351 W. Grand Blvd., Detroit 8
Kallman, Reuben R.........2631 Woodward Ave., Detroit 1
Kamil, Richard S.........14438 McNichols, Detroit 35
Kaminski, Zeno L. (L).........3510 24th St., Detroit 8
Kandel, Robert F.........Henry Ford Hospital, Detroit 2
Kane, Archibald V.........22248 Nottingham, Birmingham
Kansa, Selma.........19431 Van Dyke, Detroit 34
Kapetansky, Don I.........17376 Schaefer, Detroit 35
Kapetansky, Nathan J.........No address
Kaplita, Walter A.........60 Fontana Lane, Grosse Pte. Shores
Kapphahn, K. H.........Henry Ford Hospital, Detroit
Karadeloglow, B.........817 Virginia Park, Detroit 2
Karamatas, Philip C.........10822 W. Warren, Dearborn
Karch, Saul.........18080 Muirland, Detroit 21
Kasabach, Harry Y.........1553 Woodward Ave., Detroit 26
Kasabach, Vahram Y.........1814 Book Tower, Detroit 26
Kashtan, Harry A.........15201 W. McNichols, Detroit 35
Kasper, Jos. A.........1011 Cadieux Rd., Grosse Pte. Pk.
Kaspor, Albert J.........20901 Moross Rd., Detroit 36
Kass, Arnold.........1316 David Stott Bldg., Detroit 26
Katz, Lawrence.........987 E. Jefferson, Detroit 7
Katz, Martin.........7300 Harding, Taylor
Katzman, Harold L.........856 Fisher Bldg., Detroit
Katzman, Irving S.........412 Fox Bldg., Detroit 1
Kaufman, Jack H.........10234 W. 7 Mile Rd., Detroit

Kaufman, Louis W..............10326 W. Seven Mile, Detroit 21
Kaufman, William H...........10149 Michigan Ave., Dearborn
Kawchak, James.........................Ford Motor Co., Dearborn
Kawecki, Lucian..........10734 Hart Ave., Huntington Woods
Kawel, Conrad A., Jr...........10955 Farmington Rd., Livonia
Kazdan, Morris...............................4619 Allen Rd., Allen Park
Keemer, Edgar B., Jr.............8256 Grand River, Detroit 1
Kehoe, Henry J.......................15252 Gratiot Ave., Detroit 5
Keith, Rachel H. C. B.....................5050 Joy Rd., Detroit 4
Kelley, Frank J.................................853 Fisher Bldg., Detroit
Kelly, A. P., Jr..........................Henry Ford Hosp., Detroit 2
Kelly, Edward W., Jr.................156 Harmon St., Detroit 2
Kelly, John J...........................14729 Champaign, Allen Park
Kelly, L. J...14015 Gratiot, Detroit 5
Kelmenson, Victor A......................7356 12th St., Detroit 6
Kelson, Malcolm J.........................1045 Harvard, Detroit 30
Kennary, James M.................4900 Cadieux Rd., Detroit 24
Kennary, James M., Jr...........4900 Cadieux Rd., Detroit 24
Kennedy, Chas. S. (L)................10 Peterboro St., Detroit 1
Kennedy, Donald J.............27030 Kingswood Dr., Dearborn
Kermath, James E...................15101 Southfield, Allen Park
Kernick, Melvin O............................13700 Woodward Ave., Highland Park 3
Kernkamp, Ralph F. (L)................10 Witherell, Detroit 26
Kerwin, George R.................22149 Chatsford Cir. Southfield
Kessel, Karl J...............................18031 Kelly Rd., Detroit 24
Kessler, Chas.............................18241 Greenfield, Detroit 35
Keyes, John W...........................Henry Ford Hosp., Detroit 2
Killins, Chas. G.......................8100 E. Jefferson, Detroit 14
Kimberlin, K. K., Jr..............11110 Morang Dr., Detroit 24
King, Edward D. (L)........270 Rivard Blvd., Grosse Pte. 30
King, Melbourne J.............5435 W. Vernor Hwy., Detroit 9
King, Robert R., Jr.........Wyandotte Gen. Hosp., Wyandotte
Kingswood, Roy C.....................1078 Fisher Bldg., Detroit 2
Kitzmiller, John L.....15800 W. McNichols Ave., Detroit 35
Klaiber, Roger G.............................1541 Edsel Dr., Trenton
Klein, Herman..........................5030 Wallbrook, Birmingham
Klein, Howard A.........1846 Dav. Whitney Bldg., Detroit 26
Klein, Sander P...........14825 W. McNichols Rd., Detroit 35
Klein, Wm...................................13965 Linwood, Detroit 38
Kleinman, Shmarya (L)....................1800 Tuxedo, Detroit 6
Kliger, David...............................7756 Southfield, Detroit 28
Klimchuk, M. M.....................22770 Kelly Rd., East Detroit
Kling, George A...........................Harper Hospital, Detroit 1
Kling, Murray G...............18400 Schaefer Hwy., Detroit 35
Klosowski, Jos. (R)............8222 E. Outer Dr., Detroit 13
Kluck, Clarence J.................25210 Grand River, Detroit 40
Klutke, Geo. H. E...............................2841 Monroe, Dearborn
Knaggs, Earl J.................................2387 Fort St., Wyandotte
Knapp, Floyd B. (R)............Box 468 R. 1, Houghton Lake
Knapp, Gary H.................................23611 Goddard, Taylor
Knapp, Gordon R. (R)..........422 W. Goldengate, Detroit 3
Knapp, Wm. L...................27740 Devonshire Dr., Southfield
Knighton, Robt. S...............2799 W. Grand Blvd., Detroit 2
Knobloch, Edmund J. (L)..........5933 Chene St., Detroit 11
Knopf, Merrill M. (A)........Detroit Receiving Hosp., Detroit
Knox, Ross M............................3180 Fort St., Lincoln Park
Kobernick, Sidney D.............6767 W. Outer Dr., Detroit 35
Kobiljak, Stefan H.......................3516 Fort St., Lincoln Park
Koebel, Raymond H.....640 Bedford Lane, Grosse Pointe 30
Koek, Hendrik J.......................23100 Cherry Hill, Dearborn
Koerber, Edward J.............4876 Lakeview Ave., Detroit 15
Kogan, Natalio......................................Sinai Hosp., Detroit 35
Kogut, Constantine S.....................10627 Puritan, Detroit 38
Kokeny, Wm. J.......................................1800 Tuxedo, Detroit
Kokowicz, Raymond J...............19440 Van Dyke, Detroit 34
Kolman, Isadore I.............................1800 Tuxedo, Detroit 6
Komisaruk, Richard....................1575 E. Lafayette, Detroit 7
Kopmeyer, Joe M., Jr...............17632 Grandville, Detroit 19
Koran, Valentine L.................1306 Kales Bldg., Detroit 26
Koren, Louis.................1300 Cadillac Sq. Bldg., Detroit 26
Kornacki, Thomas E.........719 New Center Bldg., Detroit 2
Korum, Lyle W...................18585 E. Warren St., Detroit 36
Koschnitzke, H. K.....................15101 Southfield, Allen Park
Kossayda, Adam W.............15324 Michigan Ave., Dearborn
Kovach, Emery P...........................9750 Chalmers, Detroit 13
Kovan, Dennis D.....16965 Hamilton Ave., Highland Park 3
Kowaleski, John J.......................12789 Veronica, Southgate
Kozlinski, Anthony E.........2195 E. Grand Blvd., Detroit 11
Krabbenhoft, K. L..........................3825 Brush St., Detroit 1
Kraft, Ruth M..............19164 Devonshire Rd., Birmingham
Krakauer, Bernard..............17716 W. 7 Mile Rd., Detroit 35
Krass, Edward W.................11088 Gratiot Ave., Detroit 13
Kraus, John J...................16840 E. Warren Ave., Detroit 24
Krawec, Charles J.......Mt. Carmel Mercy Hosp., Detroit 35
Krebs, Wm. T...................16419 E. Warren Ave., Detroit 24
Kreinbring, Geo. E...............14295 E. 7 Mile Rd., Detroit 5
Kretzschmar, John C.............660 E. Grand Blvd., Detroit 7
Krevsky, David A.........................8449 Park Ave., Allen Park
Krevsky, Harold........................8449 Park Ave., Allen Park
Krieg, Earl G.................757 Middlesex, Grosse Pte. Pk. 30
Krieger, Harley L. (R)..........11390 Strathmoor, Detroit 27
Krieger, Harvey.........................954 Fisher Bldg., Detroit 2
Krieger, Ingeborg (A)........13112 Ladlow, Huntington Wds.
Kritchman, Maurice J...................10 Witherell St., Detroit 26
Kroha, Lawrence A.........15124 Kercheval Ave., Detroit 30
Krohn, Lawrence H.....24340 W. McNichols Rd., Detroit 19
Kroll, Harvey V.......................7815 E. Jefferson, Detroit 14
Krynicki, Francis X...................15101 W. 7 Mile, Detroit 35
Krystal, Henry.................................19210 Coyle, Detroit 35
Kubanek, Jos. L...............................23134 Myrtle, Dearborn
Kucmierz, Francis S.........18934 Van Dyke Ave., Detroit 34
Kuehn, Ned N.................20203 Wellesley Blvd., Birmingham
Kuhn, Albert A.................635 W. Seven Mile Rd., Detroit 3
Kuhn, Henry H.................635 W. Seven Mile Rd., Detroit 3
Kuhn, Richard F.....................1700 Junction Ave., Detroit 9
Kujawski, Walter F...................16840 E. Warren, Detroit 24
Kulaski, Chester H.....9309 Joseph Campau Ave., Detroit 12
Kullman, Harold J.........................930 Beechmont, Dearborn
Kuran, Lionel V...........................14853 Michigan, Dearborn
Kurcz, Jos. A.......................7433 Michigan Ave., Detroit 10
Kurtz, Irvin J.........................25210 Grand River, Detroit 40
Kurtzman, Raymond S....................Detroit Memorial Hosp., Detroit 26
Kutsche, John D................................3794 Fort St., Trenton
Kvietys, Benj.................................27235 Joy Rd., Dearborn
Kwasiborski, S. A..........................2300 Oak St., Wyandotte
Kyle, Wm. V., Jr.................................4741 Spokane, Detroit
Laberge, James M...............................100 Oak, Wyandotte
Labes, James..............................15101 W. McNichols, Detroit
Labsan, H. F...........................Henry Ford Hospital, Detroit 2
Lackey, Lawrence S...................................525 Visger, Ecorse
Laderach, David C.........................1704 Iroquois, Detroit 14
La Ferte, Alfred D. (L)..............520 St. Clair, Grosse Pte 30
Laham, M. M.................................2929 Fort St., Wyandotte
Lahood, Michael J.....................20001 Greenfield, Detroit 35
Laige, Raymond J.........................P.O. Box 1259, Detroit 31
Lajoie, Louis J.......................................601 Piquette, Detroit 2
Lakatos, George C.................................33020 Palmer, Wayne
Lake, Robt. C..........................8445 E. Jefferson, Detroit 14
Lakin, Alan C.............10326 W. Seven Mile Rd., Detroit 21
Lakin, Mervyn H...............17555 James Couzens, Detroit 35
Lakoff, Chas. B. (L)....10244 W. Seven Mile Rd., Detroit 21
Lam, Conrad R.................28130 Westbrook Ct., Farmington
Lamberson, Frank A.............19001 Grand River, Detroit 23
Lammy, James V...........748 Dav. Whitney Bldg., Detroit 26
Lamont, Richard L....................3815 Pelham Rd., Dearborn
Lamontagne, Gaetan................14801 Southfield, Allen Park
Lampman, Harold H.........3011 W. Grand Blvd., Detroit 2
Landers, Maurice B.............275 W. Grand Blvd., Detroit 16
Lang, Ernst F...............................Harper Hospital, Detroit 1
Lange, Wm. A...............1041 Cadieux Rd., Grosse Pointe 30
Langston, John D...............1420 St. Antoine St., Detroit 26
Laning, Geo. M. (L)........R. D. Morey Rd., Sharon, Conn.
Lansing, Eugene H.......................33020 Palmer Rd., Wayne
Lansky, Mandell........................16339 E. Warren, Detroit 24
Large, Alfred M.............701 Dav. Whitney Bldg., Detroit 26
Largo, Donald J...........................16717 Warwick, Detroit 19
Larkin, Duane R.............................28435 Plymouth, Livonia
Larned, Richard I.........................15208 Bringard, Detroit 5
Larsen, Edward G.......................1803 Trenton Dr., Trenton
Larsen, Robt. D.....................76 W. Adams Ave., Detroit 26
Larson, Chas. J.........................12729 Cunningham, Southgate
Larson, Francine S. ....18865 Haggerty Rd., Northville
Larsson, Bror H. (L)..................81 E. Kirby Ave., Detroit 2
Lasichak, Andrew G...............76 W. Adams Ave., Detroit 26
Lasley, James W.......1014 David Whitney Bldg., Detroit 26
Latimer, Fredk. R...........................28 W. Adams, Detroit 26
Latteier, Karl K.....................15025 W. Eight Mile, Detroit
Lauppe, Edward H...........1553 Woodward Ave., Detroit 26
Lauppe, Fredk. A.............1553 Woodward Ave., Detroit 26
Laura, Albert L...................................9105 Harrison, Livonia
Laurisin, Eugene (L)..................16554 Muirland, Detroit 21
Lauter, Eric W...................................1800 Tuxedo, Detroit 6

Lawand, Frank K.........................32377 Hazelwood, Wayne
Lawhead, Nixon R. (L)................19150 Kelly Rd., Detroit
Lawrence, Louis F.................17300 Schaefer Rd., Detroit 35
Lawson, James M.................2605 W. Grand Blvd., Detroit 8
Lawson, John W. (A)............98 Hazelwood Ave., Detroit 2
Lazar, Morton R.........................20905 Greenfield, Southfield
Leach, David.........................3011 W. Grand Blvd., Detroit 2
Leach, Robt. B..............................1401 Rivard St., Detroit 7
Leach, Wendell L.........................10811 E. Warren, Detroit 1
Leacock, Robt. C.........440 University Pl., Grosse Pointe 30
Leader, Luther R.........................801 S. Adams, Birmingham
Leaver, L. Ross......................757 Lakewood Ave., Detroit 15
Lebamoff, Alexander T.............7940 Allen Rd., Allen Park
Lechner, Monroe S.................22770 Kelly Rd., East Detroit
Lecklider, A. F. (R)........848 Berkshire Rd., Grosse Pte 30
Lee, Edith J..................................150 Massachusetts, Detroit
Lee, Frank............................501 Meadowlane Dr., Dearborn
Lee, Harry E. (L)....................13616 Gratiot Ave., Detroit 5
Lee, Pyong Tai......................26559 Grand River, Detroit 40
Leeser, Robert L.................23100 Cherry Hill Rd., Dearborn
Lehmann, Robert N.....26029 W. Five Mile Rd., Detroit 39
Leipsitz, Louis S..............................3566 Cass Ave., Detroit 1
Leiter, Forrest C..............................2355 Monroe, Dearborn
Leithauser, Danl. J. (L)..................18412 Mack, Detroit 36
Leland, Solomon.........................6563 Grand River, Detroit 8
Lemley, Clark F...................3011 W. Grand Blvd., Detroit 2
Lemmon, Chas. E. (L)................1337 Dav. Whitney Bldg., Detroit 26
Lemon, Bruce K.........................20905 Greenfield, Southfield
Lentine, James J........................15831 Mack Ave., Detroit 24
Lenz, Willard R...........................418 Moran Rd., Detroit 36
Lenzo, Joseph E...........................951 E. Lafayette, Detroit 7
Lepard, Cecil W.................1553 Woodward Ave., Detroit 26
Lepley, Fred O. (L)......19799 Mack Ave., Grosse Pte. Wds.
Lepley, Frederick J...................19803 Mack, Grosse Pte. 36
Lerman S. I.................................18330 Parkside, Detroit 21
Lerner, A. Martin................1400 Chrysler Exp., Detroit 7
Lerner, Leonard H.......7310 W. Seven Mile Rd., Detroit 21
Lesesne, John M...........17700 Mack Ave., Grosse Pointe 24
Leslie, C. G..................................8401 Woodward, Detroit 2
L'Esperance, Simon P. (R)....Rt. 3, Woodslee, Ont., Canada
Lessem, David..................12759 Vernon, Huntington Woods
Lester, Melvin A................................20145 Lander, Detroit
Leszynski, Jos. S. (L)...No address
Leucutia, Traian (L)..........................10 Peterboro, Detroit 1
Levagood, Floyd B.............224 Professional Bldg., Detroit 1
Levant, Arthur B.......................15715 E. Warren, Detroit 24
Levenson, Malcolm L......................24500 Curtis, Southfield
Leventer, Ira....................20211 Ann Arbor Trail, Dearborn
Levick, Walter G.....................19959 Vernier, Harper Woods
Levin, David M. (A)........3505 E. Campbell, Phoenix, Ariz.
Levin, Herbert G.........................17300 Schaefer, Detroit 35
Levin, M. Mitchel......................20905 Greenfield, Southfield
Levin, S. J.........................3011 W. Grand Blvd., Detroit 2
Levine, Edward E.........12891 Sherwood, Huntington Woods
Levine, Sydney S.............8233 W. Chicago Blvd., Detroit 4
Levitt, Irving...........................24535 N. Carolina, Southfield
Levitt, Nathan (L)......................607 Kales Bldg., Detroit 26
Levy, David B....................................29586 Fenkell, Livonia
Levy, Marvin B.................23200 Woodward Ave., Ferndale
Levy, Stanley H..............10601 Seven Mile Rd., Detroit 21
Lewin, Harry (L)........2735 W. McNichols Rd., Detroit 1
Lewis, Benjamin M..........................1401 Rivard, Detroit 7
Lewis, Chas. T. (L)........................5050 Joy Rd., Detroit 4
Lewis, Harvey Y.........14219 W. McNichols Rd., Detroit 35
Lewis, J. Hugh............................1543 Ford Ave., Wyandotte
Lewis, Lee A...............................2730 E. Jefferson Ave., Detroit 7
Lewis, Robt. H.................14807 W. McNichols, Detroit 35
Lewis, Wilfrid J...........................10 Peterboro St., Detroit 1
Libbrecht, Robt. V.....................6540 Park Ave., Allen Park
Lichter, Max L.................2900 Oakwood Blvd., Melvindale
Lichty, Dorman E.........................7701 Wyoming, Dearborn
Liddicoat, Arthur G.....................20125 Fenkell, Detroit 23
Lie, Kim K.............................1408 Kales Bldg., Detroit 26
Lieberman, Barnard L.....19212 Woodward Ave., Detroit 3
Lightbody, James J.............1553 Woodward Ave., Detroit 26
Lignell, Rudolph W...401 Northland Med. Bldg., Southfield
Liioi, Joseph A.................17000 W. 8 Mile Rd., Southfield
Lilly, Robert P....................29594 W. Five Mile Rd., Livonia
Lindner, David W.........801 Dav. Whitney Bldg., Detroit 26
Linkner, Leonard S..............................12944 La Salle Lane, Huntington Woods

Lipinski, Stanley L...............7540 Michigan Ave., Detroit 10
Lipkin, Ezra.......................5715 Michigan Ave., Detroit 10
Lipnik, Carl E.........................31610 Plymouth Rd., Livonia
Lipnik, Morris J.................17000 W. Eight Mile, Southfield
Lipschutz, Louis S...........19750 Chesterfield Rd., Detroit 21
Lipson, Channing T.........20101 James Couzens, Detroit 35
Lipson, Madeleine L..........................1800 Tuxedo, Detroit 6
Lipton, Raymond F.....................10 Peterboro St., Detroit 1
Litsky, Abraham D.............1183 E. Grand Blvd., Detroit 11
Little, James W.............3637 Franklin Rd., Bloomfield Hills
Litwin, Jack A.............15121 W. McNichols Rd., Detroit 35
Litzenberger, D. J.......................18891 Quary Rd., Riverview
Livingood, Clarence S.............345 University, Grosse Pte. 30
Livingston, W. C.............................18060 Conant, Detroit 34
Lloyd, James R...........1515 Dav. Whitney Bldg., Detroit 26
Lo, Lien Fu...1800 Tuxedo, Detroit 6
Lo, Molly Tan...............................Sinai Hospital, Detroit 35
Lockhart, Edward C..................1700 W. Grand Blvd., Detroit
Lockwood, Bruce C. (L)......19490 Parkside Rd., Detroit 21
Lofstrom, James E.............1420 St. Antoine St., Detroit 26
Logrippo, Annie B......................Henry Ford Hosp., Detroit 2
Lohmann, Carl W.........1229 Dav. Whitney Bldg., Detroit 26
London, Berton L........................18510 Meyers, Detroit 35
Long, Earl C. (L)....19751 James Couzens Hwy., Detroit 35
Long, John J.....................15901 Greenfield Ave., Detroit 27
Longo, Salvatore...............................468 Cadieux, Detroit 30
Loomus, Gerald N...............4100 W. McNichols, Detroit 21
Lopatin, Reuben...............................1800 Tuxedo, Detroit 6
Loranger, C. B. P.............................20825 Mack, Detroit 36
Loranger, Guy L..........................34 Moross Rd., Detroit 36
Lorber, Jos. H.....................873 Lakewood Ave., Detroit 15
Lorentzen, Edwin H. (L)................11702 Grand River Ave., Detroit 4
Lovas, Wm. S...............................6354 W. Fort St., Detroit 9
Love, Donald M.....................703 Parker, Apt. 4, Detroit 14
Love, W. Thos.........................231 E. Warren Ave., Detroit 1
Lowe, Adolf W.................3338 W. Davision Ave., Detroit 38
Lowinger, Paul L........................951 E. Lafayette, Detroit 7
Lowrie, Wm. L..................2799 W. Grand Blvd., Detroit 2
Luby, Elliot D..........................19680 Roslyn Rd., Detroit 21
Lucas, Robert J..........................771 Fisher Bldg., Detroit 2
Lui, Alfred H. F..............Wayne Co. Gen. Hospital, Eloise
Lukas, John R........................18551 W. Warren, Detroit 28
Lumpkin, John G., Jr...........243 E. Warren Ave., Detroit 1
Lutz, Earl F...........2920 N.E. 55th St., Ft. Lauderdale, Fla.
Lutz, Sherwin J.................15121 W. McNichols, Detroit 35
Luz, Denis A.........................Bon Secours Hosp., Grosse Pte.
Luzadre, John H.......................18430 Mack Ave., Detroit 36
Lynn, David H.........................Lynn Hospital, Lincoln Park
Lynn, Harvey D.........................3815 Pelham Rd., Dearborn
Lytle, Robt. P...........402 Northland Med. Bldg., Southfield
Maben, Hayward C., Jr. (A)..............9342 Oakland, Detroit
Mabley, John D.................1037 David Whitney, Detroit 26
MacCraken, F. L. (A)................16753 St. Mary, Detroit 35
MacDougall, Orrin P.........13700 Woodward Ave., Detroit 3
MacFarlane, Howard W.....1553 Woodward Ave., Detroit 26
MacGregor, Wm. W. (L)................1111 N. Woodward Ave., Birmingham
Mack, Harold C...................3011 W. Grand Blvd., Detroit 2
Mack, Robert E.........................Woman's Hospital, Detroit 1
MacKenzie, Earl D.......................81 E. Kirby St., Detroit 2
MacKenzie, John W. (L)............................289 Rivard Blvd., Grosse Pointe 30
Mackersie, Wm. G. (L)....18205 Roselawn Ave., Detroit 21
MacLeod, Chas. W.............16345 W. McNichols, Detroit 35
MacMillan, Francis B.........1553 Woodward Ave., Detroit 26
Mac Neil, John J.............2075 E. 14 Mile Rd., Birmingham
MacPherson, K. C. (L)............8100 E. Jefferson, Detroit 14
MacQueen, Malcolm D. (L)................660 Woodward Ave., Detroit 26
Maczewski, John E...................24735 Van Dyke, Centerline
Mader, Ivan J.......26111 Woodward Ave., Huntington Wds.
Magnell, Ralph C...................8825 Puritan Ave, Detroit 38
Maguire, Clarence E.........1553 Woodward Ave., Detroit 26
Mahanti, Biresh C.........................2300 Oak St., Wyandotte
Mahlin, Murray S.............16820 Greenfield Ave., Detroit 35
Mahoney, Hugh M.............1553 Woodward Ave., Detroit 26
Maibauer, Fredk. P.................2934 Biddle Ave., Wyandotte
Maino, Linus J.....................2501 W. Grand Blvd., Detroit 8
Mainwaring, Rosser L.......................1910 Russell, Dearborn
Mainzer, Jacob...................................1381 Linden, Plymouth

Maire, Edward D....15224 E. Jefferson, Detroit 30
Maisel, Harry....8233 W. Chicago, Detroit 4
Maitland, Ruth J....Mich. Bell Telephone, Detroit 26
Majauskas, V. E....23738 Joy Rd., Detroit 39
Majzoub, Ahmad J....3334 Fort, Lincoln Park
Malina, Stephen....1601 Kirkway Dr., Rt. 3, Bloomfield Hills
Malje, Frank J....Garden City Clinic, Garden City
Malone, John M....17300 Schaefer Rd., Detroit 35
Malone, Robert J....15101 Southfield, Allen Park
Maloney, John A. (L)....670 Maccabees Bldg., Detroit 2
Maloney, Philip J....16401 Grand River, Detroit 27
Maltzer, Jos. H....26505 John R, Madison Heights
Mammel, Bernard T....14447 W. Seven Mile Rd., Detroit 35
Mancuso, Vincent S. (L)....611 S.W. 38th Ave., Ft. Lauderdale, Fla.
Mandel, Leslie....22341 W. 8 Mile Rd., Detroit 35
Mandell, Gerald H....Sinai Hospital, Detroit 35
Mandiberg, Jack N....12700 W. 7 Mile Rd., Detroit 35
Mann, Andrew D....20901 Moross, Detroit 36
Manning, Morey H....950 E. State Fair Ave., Detroit 3
Manson, Gordon....Henry Ford Hosp., Detroit 2
Mapletoft, Kenneth E....420 Mohawk, Dearborn
Marcus, Edwin L....15101 Southfield, Allen Park
Marecki, Vincent J....10326 W. Warren, Dearborn
Margolis, Marvin O....Herman Kiefer Hosp., Detroit
Margules, Saul Z. (A)....11846 E. McNichols, Detroit 5
Marinus, Carleton J. (L)....1553 Woodward Ave., Detroit 26
Mark, Jerome....513 David Whitney Bldg., Detroit 26
Markey, Alexander P....14853 Michigan Ave., Dearborn
Markey, Frank R....17174 Fairfield, Detroit 21
Markoe, Rupert C. L....7600 John R St., Detroit 2
Marks, Ben....232 W. Grand River Ave., Detroit 26
Marks, Bert W....8250 Lincoln Dr., Huntington Woods
Marsh, Alton R. (L)....15696 Woodland Dr., Dearborn
Marshall, James R. (L)..14827 E. Jefferson Ave., Detroit 15
Marshall, J. R., Jr....20160 Mack Ave., Detroit 36
Martin, J. B., Jr....449 E. Elizabeth St., Detroit 1
Martin, Lyndle R....2000 Second Blvd., Detroit 26
Martin, Peter A....857 Fisher Bldg., Detroit 2
Martin, Walter....17523 DeQuinder, Detroit 12
Martin, Wilbur C....2536 W. Grand Blvd., Detroit 6
Martineau, Perry C....Herman Kiefer Hosp., Detroit
Martinez, Alvardo....15830 Fort St., Southgate
Martinez, Pedro O....1439 Bagley Ave., Detroit 16
Martmer, Edgar E....693 Washington Rd., Grosse Pointe 30
Marvin, Robert C....1678 Marriman Rd., Wayne
Marwil, Thos. B....17563 Greenfield Rd., Detroit 35
Mateer, John G. (L)....Henry Ford Hospital, Detroit 2
Mathis, Perry L....3239 Clements, Detroit 38
Matthews, Burton V....13724 W. Fort St., Southgate
Mattman, Paul E....1500 Seminole, Detroit 14
Mattson, Theo. M....2730 Maybury Grand, Detroit
Mauch, Eugene W....15101 Southfield, Allen Park
Mauthe, Harry G....16859 Pollyana Dr., Livonia
Maynard, Fredk. M....6828 Park Ave., Allen Park
McAlonan, William T. (L)....10 Peterboro St., Detroit 1
McAlpine, Gordon S. (L)....3011 W. Grand Blvd., Detroit 2
McBryan, Thos. J....Grace Hosp., Detroit
McCadie, James H....13700 Woodward Ave., Highland Park 3
Mc Call, Marion G., Jr....2930 W. Grand Blvd., Detroit
McCandless, Virginia....270 S. Melborn, Dearborn
McCaughey, R. S....Wayne St. University, Detroit 7
McClellan, Robt. J....16345 W. McNichols, Detroit 35
McClelland, Rachel L....33026 Five Mile Rd., Livonia
McClendon, James J....8401 Woodward, Detroit 2
McClintock, John J. (L)....41449 Wilcox Rd., Plymouth
McClure, Robt. W....9111 E. Outer Dr., Detroit 13
McClure, Wm. R. (L)....Box 1498, Boynton Beach, Fla.
McCole, C. E....Henry Ford Hospital, Detroit 2
McColl, Chas. W....2025 Ford Ave., Wyandotte
McColl, Clarke M....2799 W. Grand Blvd., Detroit 2
McCollum, E. Bert....1553 Woodward Ave., Detroit 26
McCord, Carey P. (L)....Sch. of Public Health, Ann Arbor
McCormick, Colin C. (A)....24352 Rockford Ave., Dearborn
McCue, Francis B....6742 Park Ave., Allen Park
McCullough, L. E....1711 David Whitney Bldg., Detroit 26
McDonald, Angus L. (L)....15125 Gratiot, Detroit 5
McDonald, John R....Harper Hosp., Detroit 6
McDonald, Wm. G....15600 Michigan Ave., Dearborn
McEvitt, Wm. G....1140 W. Boston Blvd., Detroit 2
McGee, T. Manford....20905 Greenfield, Southfield
McGillicuddy, W. E. (R)....7542 Pinehurst, Dearborn
McGinnis, Kenneth D....Henry Ford Hospital, Detroit 2
McGlaughlin, N. D....2312 Biddle Ave., Wyandotte
McGough, Jos. M....18716 Grand River, Detroit 23
McGuire, John F....610 Northland Med. Bldg., Southfield
McHenry, John T....1401 Rivard St., Detroit 7
McHenry, Martin....Henry Ford Hosp., Detroit
McIntosh, Robt. D....6307 W. Fort St., Detroit 9
McIntyre, Wm. B....1145 David Whitney Bldg., Detroit 26
McKean, G. Thos....1553 Woodward Ave., Detroit 26
McKeever, Geo. E....5237 Oakman Blvd., Dearborn
McKenna, Chas. J....14618 E. 7 Mile, Detroit 5
McKnight, Robt. E....20905 Greenfield, Southfield
McLane, Harriet I. E. (L)....4350 Oregon Ave., Detroit 4
McLaurin, Jasper E....5050 Joy Rd., Detroit 6
McLean, Brita R....1365 Cass, Detroit 26
McLean, Don W....1066 Fisher Bldg., Detroit 2
McLean, Donald C....10 Peterboro, Detroit 1
McNamara, Joseph M....9430 S. Main, Plymouth
McNeill, Roger F....119 Kercheval, Grosse Pointe
McNichol, L. J....18424 W. McNichols Rd., Detroit 19
McPhee, Roderick T....21503 Harper, St. Clair Shores
McQuiggan, Mark C....15121 W. McNichols Rd., Detroit 35
McQuiggan, Mark R....700 Seward, Detroit 2
Medalie, Morris....1800 Tuxedo, Detroit 6
Meek, Stuart F....19701 Fleetwood, Harper Woods
Meghnot, Parviz....1800 Tuxedo, Detroit 6
Melander, L. W., Jr....1229 David Whitney Bldg., Detroit 26
Mellen, Hyman S....16800 Greenfield, Detroit 35
Mellinger, Raymond C....959 Pemberton, Grosse Pointe
Melnik, Maxim P....3011 W. Grand Blvd., Detroit 2
Melnyczuk, Nestor....19600 W. Warren, Detroit 10
Menagh, Frank R. (L)....4010 Columbus Ave., Detroit 4
Menczer, Richard....19321 Greenfield, Detroit 35
Mendelson, Charles G....Henry Ford Hospital, Detroit 2
Mendelson, Herbert....15200 Northfield, Oak Park 37
Mendelssohn, Reuben J....8100 E. Jefferson, Detroit
Mendians, Edgar V....9486 Beaconsfield, Detroit 24
Mendoza, Saml....6356 Michigan, Detroit
Menton, Norman J....15300 W. McNichols, Detroit 35
Merkel, Chas. C....85 Kercheval Ave., Grosse Pointe Farms
Merkle, Karl....530 N. Telegraph, Dearborn
Merrill, C. R., Jr....1951 Monroe, Dearborn
Merritt, Earl G....10 Peterboro St., Detroit 1
Mersky, Charlotte I. (A)....32215 Queensboro, Farmington
Metes, John S....62 Webber Pl., Grosse Pointe Shores
Metzger, Harry C....25504 Wareham, Huntington Woods
Meyer, Eugene....15830 Ford St., Southgate
Meyer, John S....Wayne State Univ., Detroit 7
Meyer, Kenneth R....Oakwood Hosp., Dearborn
Meyers, Marjorie P....5320 John R St., Detroit 2
Meyers, Maurice P....18984 Livernois, Detroit 21
Meyers, Solomon G....966 Fisher Bldg., Detroit 2
Michael, Michael J....703 Mutual Bldg., Detroit 26
Mihay, Benjamin....2021 Monroe, Dearborn
Mikesell, W. B., Jr....23611 Goddard, Taylor
Milad, Amis A....25701 Joy Rd., Dearborn Hghts.
Mileris, Vytautas....2730 E. Jefferson Ave., Detroit 7
Millard, Glenn E....958 Fisher Bldg., Detroit
Miller, Danl. H....23100 Cherry Hill, Dearborn
Miller, Elmer B....20 Oxford Rd., Pleasant Ridge
Miller, George W....Whittier Hotel, Detroit 14
Miller, Jacob J....20131 James Couzens, Detroit 35
Miller, J. Martin....2799 W. Grand Blvd., Detroit 2
Miller, Karl L....1553 Woodward Ave., Detroit 26
Miller, Myron H. (L)....27330 Southfield Rd., Lathrup Village
Miller, Oscar W....Fleetwood Plant, FBD, GMC, Detroit 9
Miller, Thos. H....1305 David Whitney Bldg., Detroit 26
Miller, Wm. E. (L)....10 Peterboro, Detroit 1
Miller, William J....5649 Inkster Rd., Garden City
Mills, Clinton C....16190 Jas. Couzens Hwy., Detroit 21
Mills, Geo. R....8209 Allen Rd., Allen Park
Milton, S. Byron....26560 W. Outer Dr., Lincoln Park
Mines, Robert E., Jr....8401 Woodward Ave., Detroit 2
Mintz, Edward I....954 Fisher Bldg., Detroit 2

Mintz, Morris J......16895 Livernois St., Detroit 21
Minui, Morteza......1144 Carlson, Wayne
Mishelevich, Sophie (L)......4651 E. Nine Mile Rd., Warren
Miskinis, Martyna......393 W. Grand Blvd., Detroit 16
Missavage, Edward, Jr......Wayne Co. Gen. Hosp., Eloise
Mitchell, A. W......12000 Visger, Detroit
Mitchell, C. Leslie......Henry Ford Hospital, Detroit 2
Mitchell, Darnell P......8401 Woodward Ave., Detroit 2
Mitchell, Roy A......316 Helen Ave., Trenton
Moehlig, Robt. C. (L)......3001 W. Grand Blvd., Detroit 2
Moghissi, Kamran S...763 David Whitney Bldg., Detroit 26
Mogill, Geo......3150 Second Blvd., Detroit 1
Moisides, Vasil P. (L)......28 W. Adams Ave., Detroit 26
Moll, Clarence D......10 Peterboro St., Detroit 1
Molnar, Stephen K......4525 S. Telegraph Rd., Dearborn
Molner, Jos. G......14890 Glastonbury Rd., Detroit
Momcilovich, Boxidar......2241 Huron River Dr., Rockwood
Mond, Edward......10 Witherell St., Detroit 26
Monson, Robt. C......17520 Chester, Detroit 24
Montante, Jos. R......18715 Bretton Dr., Detroit 23
Montenegro, Milton......18512 Hillcrest, Livonia
Montgomery, Wm. C......26711 Woodward, Huntington Woods
Monto, Raymond W......Henry Ford Hospital, Detroit 2
Moore, John W., Jr.....8251 W. Eight Mile Rd., Detroit 21
Moore, Warren R......17800 E. 8 Mile Rd., Detroit 36
Mopper, Coleman......14633 E. Seven Mile Rd., Detroit 5
Moran, Frank J......27459 Five Mile Rd., Livonia
Morand, Louis J. (A)......18944 Fairfield, Detroit 21
Moreno, Louis J......8830 W. McNichols Rd., Detroit 21
Morgan, Donald N......1553 Woodward Ave., Detroit 26
Morgan, Philip J......1575 Cherboneau A53, Detroit 26
Moriarty, Geo. J......3011 W. Grand Blvd., Detroit 2
Morita, Yoshikazu......26111 Woodward Ave., Huntington Woods
Morley, Arthur R......15753 Promenade, Allen Park
Morley, George M......12922 W. Warren, Dearborn
Morley, Harold V......970 Fisher Bldg., Detroit 2
Morley, James A. (L)......10514 Plymouth Ave., Detroit 4
Moroun, Sheffick J......675 Parker, Detroit 14
Morris, Harold L. (L)......26111 Meadowbrook Rd., Novi
Morrison, George W......2033 Park, Detroit 26
Morse, William H......19203 Grand River, Detroit 23
Morton, David G......19445 Plymouth, Detroit 28
Moscovic, Edward A......Oakwood Hospital, Dearborn
Moseley, Fredk. L......2561 S. Schaefer, Detroit
Mosen, Max M. (A)......26116 York Rd., Huntington Woods
Moser, Peter F......26151 Huron River Dr., Flat Rock
Moses, John W......754 Fisher Bldg., Detroit 2
Moss, Ervin B. (A)......23295 Kipling, Oak Park
Moss, Nathan H......2847 Trumbull, Detroit 16
Moss, Norman D......25415 Southfield Rd., Southfield
Moss, Selma S......20905 Greenfield, Southfield
Mott, Carlin P. (L)......2395 W. Grand Blvd., Detroit 8
Moynihan, John W......2841 Monroe Blvd., Dearborn
Mozen, Herschel E......12950 W. Chicago Blvd., Detroit 28
Mucasey, John......21415 W. 8 Mile Rd., Detroit 19
Mullen, Jos. R......19003 Ecorse Rd., Allen Park
Munson, Henry T......18350 Mack, Grosse Pointe 36
Murphy, Donald J. (A)......607 Highland Park Dr., Billings, Montana
Murphy, Scipio G......603 E. Forest, Detroit 1
Murphy, Wm. M......10500 E. Warren Ave., Detroit 14
Murray, Gordon M......9901 Whittier, Detroit 24
Murray, Robt. J......3700 West Rd., Trenton
Murray, Thomas H......25239 Southfield, Southfield
Muske, Paul H......13244 W. Warren, Dearborn
Myers, Danl. W......1150 Bedford Rd., Detroit 30
Nahigian, Russell......17371 Annchester Ave., Detroit 19
Nahoum, Antoine......1030 Kensington, Detroit 30
Nash, Edward B......4075 Inkster Rd., Inkster
Naud, Henry J......18456 Grand River Ave., Detroit 23
Naud, Joseph H......412 David Whitney Bldg., Detroit 26
Navori, Cornelius A......3516 Fort St., Lincoln Park
Naylor, Arthur H. (L)......2100 N. Tipsico Lk. Rd., Milford
Neeb, Walter G......16840 E. Warren St., Detroit 24
Nehra, John M......320 E. Center Prof. Bldg., Detroit 36
Neill, Edwin J......5026 Bedford, Detroit 14
Nelson, Darwin M......63 Ridge Rd., Detroit 36
Nelson, Harry M. (L)......3001 W. Grand Blvd., Detroit 2
Nelson, Norman A......Wayne Co. Gen. Hosp., Eloise
Nelson, Victor E......3025 Crooks Rd., Royal Oak
Nesbit, Warren S......474 Fisher Bldg., Detroit 2
Netreba, Jules L......25210 Grand River, Detroit
Neufeld, Paul N......17000 W. 8 Mile Rd., Southfield
Newman, Ernest (R)......17371 Evergreen St., Detroit 19
Newman, Geo. F......2021 Monroe Blvd., Dearborn
Newman, Max K......16861 Wyoming Ave., Detroit 21
Newton, Kenneth......11841 Susan Ave., Warren
Nichols, Wallace, Jr......3631 S. Longmeadow, Trenton
Nickel, Warren O......861 Monroe, Dearborn 8
Nickels, Albert W......3011 W. Grand Blvd., Detroit 2
Nielsen, Aage E......320 Professional Bldg., Detroit 1
Nielsen, Donald R......26339 Woodward Ave., Huntington Woods
Nigro, Norman D......7815 E. Jefferson, Detroit 14
Nill, John B. (L)......15001 E. Warren, Detroit 24
Nill, Wm. F. (L)......15001 E. Warren, Detroit 24
Noble, Wm. C......4045 W. Jefferson, Ecorse 29
Nolan, Bernard E......5460 Schaefer Rd., Dearborn
Nolting, Wilfred S. H.....15850 E. Warren Ave., Detroit 24
Northcross, David C......2929 W. Boston Blvd., Detroit 6
Norton, Arthur B. (L)......1077 Fisher Bldg., Detroit 2
Noshay, Wm. C......2799 W. Grand Blvd., Detroit 2
Novack, Richard L......15930 Shadyside, Livonia
Novy, Robt. L. (L)......858 Fisher Bldg., Detroit 2
Nowosielski, P. F......15256 Levan Rd., Livonia
Nwokedi, C......12000 Visger Road, Detroit 17
Nyboer, Jan......Harper Hospital, Detroit 1
O'Brien, Geo. M......2501 W. Grand Blvd., Detroit 8
Obushkevich, Leon S......15720 W. Warren, Detroit 28
O'Connor, Katheryn L......17711 Schoolcraft, Detroit 27
O'Donnell, Dayton H......2501 W. Grand Blvd., Detroit 8
Oetting, Edward M......1041 Whittier, Grosse Pointe
O'Gawa, Gilbert M. (M)......Henry Ford Hospital, Detroit
Ohmart, Galen B......8721 E. Jefferson Ave., Detroit 14
Okun, Milton H......3261 Sherbourne Rd., Detroit 21
Oldford, Joseph R......17000 W. 8 Mile Rd., Detroit 35
Olejniczak, Stanley......Wayne Co. Gen. Hosp., Eloise
Olen, Alex......13100 Harper Ave., Detroit 13
O'Linn, Francis P......1055 Fisher Bldg., Detroit 2
Olmsted, Geo. S......27305 Southfield Rd., Lathrup Village
Olson, Avis M......Mt. Carmel Mercy Hosp., Detroit 35
Olson, Donald T......17701 W. McNichols Rd., Detroit 35
Olson, James A......17000 West 8 Mile Rd., Southfield
Oppenheim, Jos. M......24091 Dante, Oak Park 37
Organ, Fred W. (L)......131 Moss Ave., Highland Park 3
Ormond, Robt. S......1951 Monroe St., Dearborn
O'Rourke, Paul V......2635 Woodstock, Detroit 3
O'Rourke, Randall M......7384 12th St., Detroit 6
Osius, Eugene A......901 Dav. Whitney Bldg., Detroit
Ostrowski, Arthur Z...610 Northland Med. Bldg., Southfield
Otlewski, Eugene A......20905 Greenfield, Southfield
Ottaway, John P.....18226 Mack Ave., Grosse Pointe Farms
Otto, Donald......Det. Memorial Hospital, Detroit 26
Owen, Clarence I. (L)......2689 Dupont, Jacksonville, Fla.
Packer, Robert (A)......Detroit Receiving Hosp., Detroit
Palmer, Alice E. (A)......Park Shelton Hotel, Detroit
Palmer, Milton R......8700 Dexter Blvd., Detroit 6
Palmisano, I. J......25447 Plymouth Rd., Detroit 39
Panczak, Tamara......Plymouth State Hosp., Northville
Panic, Stephen M......1001 W. Seven Mile, Detroit 3
Pantos, Theo. G......1536 David Whitney Bldg., Detroit 26
Parejo, Jose M......4342 W. Vernor, Detroit 9
Parfanowycz, S. N. (A)......3347 Grant St., Detroit 12
Parker, Albert R......3720 Washington St., Wayne
Parker, Benj. R......19149 W. Seven Mile Rd., Detroit 19
Parnell, John W......21 Whitcomb Dr., Grosse Pointe Farms
Parr, Robt. W. (A)....1126 Audubon Rd., Grosse Pointe 30
Parrish, Rufus H. (A)......2610 Starlevant, Detroit
Pasternacki, N. T......6203 Chene St., Detroit 11
Pastorius, Melvin K......5947 Middlesex, Dearborn 1
Patton, Roy B......Henry Ford Hospital, Detroit 2
Paul, Lloyd J......19321 Greenfield, Detroit
Pawlowski, Jerome I. (L)....2009 E. Grand Blvd., Detroit 11
Payne, Eugene H. (R)......Box 852, Mariana, Fla.
Payne, Walter A., Jr......357 Hillcrest, Grosse Pointe 36
Paysner, Harry A......13700 Woodward Ave., Highland Park 3

Pearce, Arthur J.................15317 Piedmont St., Detroit 23
Pearlman, Jack................25860 Concord, Huntington Woods
Pearse, Harry A...................17000 W. Eight Mile, Southfield
Pedersen, Herbert E...................3815 Pelham Rd., Dearborn
Peggs, Geo. F...........................5419 Livernois Ave., Detroit 10
Pendy, Geo. V.............1001 David Whitney Bldg., Detroit 26
Pendy, John M.........1001 David Whitney Bldg., Detroit 26
Penner, David A.........18530 Grand River Ave., Detroit 23
Pensler, Leslie..................................10151 Michigan, Dearborn
Pensler, Meyer................10151 Michigan Ave., Dearborn 2
Percy, Donald F.............15901 Greenfield Ave., Detroit 27
Perdue, Grace M.................3011 W. Grand Blvd., Detroit 2
Perez Borja, C. M. (A)...........Receiving Hospital, Detroit
Perez Gurri, Jose L...................3150 Carpenter, Detroit 12
Perkin, Frank S................3011 W. Grand Blvd., Detroit 2
Perlis, Hyman L. (L).......................10 Peterboro, Detroit 1
Perlis, Marvin S.........................1030 Fisher Bldg., Detroit 2
Perry, Joseph H.............259 Lewiston Rd., Grosse Pointe 36
Peterman, Earl A...........13700 Woodward, Highland Park 3
Petermann, Claus............1900 Dav. Broderick Twr., Detroit 2
Peters, Wm. R...............12400 E. Seven Mile Rd., Detroit 5
Peterson, Gustav............Fisher Body, Willow Run, Ypsilanti
Petix, Samuel C.............................19207 Schaefer, Detroit 35
Petoskey, Edward A.........................5656 W. Fort, Detroit 9
Petrick, Thos. J.........................15101 Southfield, Allen Park
Petrini, Mario A.........................1080 Fisher Bldg., Detroit 2
Petrucco, Louis A..........................15400 Plymouth, Detroit
Petty, Thos. A...........17300 E. Jefferson Ave., Grosse Pointe
Petz, Arthur John.........................15420 Farmington, Livonia
Petz, Thomas J.........1139 David Whitney Bldg., Detroit 26
Peven, Philip S.......................18709 Meyers Rd., Detroit 35
Picard, Jos. D.........................5237 Oakman Blvd., Dearborn
Piccone, Louisa I.....................17700 W. Warren, Detroit 28
Pichette, J. Walton................6650 Greenfield Rd., Dearborn
Pickard, Orlando W. (L)..14300 W. McNichols, Detroit 35
Pickering, L. M............................15830 Fort St., Southgate
Pierce, James M., Jr...........Wayne St. University, Detroit 7
Pietra, A. W.....................10338 Joseph Campau, Detroit 12
Piligian, John T....................................3825 Brush, Detroit 1
Pingel, James F.................................998 Norfolk, Birmingham
Pink, Rose M...................11413 Joseph Campau, Detroit 12
Pinney, Lyman J. (L)....................28 W. Adams, Detroit 26
Pino, Ralph H. (L)......48151 W. Ann Arbor Rd., Plymouth
Piper, Ralph R.............................1495 McKinstry, Detroit 9
Pittman, John E. (L)........1553 Woodward Ave., Detroit 26
Pitts, Kenneth E.....................17850 Maumee, Grosse Pointe
Platz, Carol K.............612 Est. Cen. Prof. Bldg., Detroit 36
Plavnick, Herman M....................13300 Fenkell, Detroit 27
Pliskow, Harold........10730 W. Seven Mile Rd., Detroit 21
Plotnick, Harold..........................18654 Muirland, Detroit 21
Plous, Eugene I...........................569 Fisher Bldg., Detroit 2
Podolsky, Harold M......................3755 Fort, Lincoln Park
Pogrebniak, A....................25210 Grand River, Detroit 40
Poim, Senta V.................................10 Peterboro, Detroit 1
Polentz, Chas. P.........Medical Concourse N. C., Southfield
Polk, John E...................................8742 12th St., Detroit 6
Pollack, Jerome L.....................14551 Southfield, Allen Park
Pollack, John J...........................18200 Wyoming, Detroit 21
Pollard, R. J.......................................Grace Hosp., Detroit 1
Pollens, Louis S...........12730 W. McNichols Rd., Detroit 35
Pollina, Clement J.................21503 Harper, St. Clair Shores
Ponka, Jos. L.......................2799 W. Grand Blvd., Detroit 2
Pool, Walter D.......................20901 Moross Rd., Detroit 36
Poos, Edgar E. (L)............3001 W. Grand Blvd., Detroit 2
Pope, Gerald............................Henry Ford Hosp., Detroit 2
Porretta, Chas. A.... .507 Northland Med. Bldg., Southfield
Porretta, Francis S.....18591 Saratoga Blvd., Lathrup Village
Porretta, George F.....................20905 Greenfield, Southfield
Porter, Fredk. G.............................29590 Five Mile, Livonia
Porter, Howard J. (A).............................2555 S.E. 7th St.,
Pompano Beach, Fla.
Portnoy, Harry............................18010 Roselawn, Detroit 21
Posch, Jos. L...............................1410 Kales Bldg., Detroit 26
Posner, Irving....................18111 Muirland Ave., Detroit 21
Postigo, Julio C.................................4401 Conner, Detroit 15
Potts, Elihue B....................................7404 Dexter, Detroit 6
Poznanski, Andrew K.........Henry Ford Hospital, Detroit 2
Pracher, John R..........................3815 Pelham Rd., Dearborn
Prasad, Ananda S.............Wayne State University, Detroit 7
Pratt, Jean P. (L)................18910 Fairway Dr., Detroit 21
Pratt, Lawrence A. (A)...........................USOM, APO 143,
San Francisco, Calif.
Preston, Ruth E.....................3011 W. Grand Blvd., Detroit 2
Price, A. Hazen............408 David Whitney Bldg., Detroit 26
Price, Alvin E...................1553 Woodward Ave., Detroit 26
Priest, Robt. J.......................Henry Ford Hospital, Detroit 2
Primack, Marvin H.............................7430 Second, Detroit 2
Prince, Addison E...............................8942 Dexter, Detroit 6
Prisbe, Edward J.................16603 Plymouth Rd., Detroit 27
Priver, Julien...........................6741 W. Outer Dr., Detroit 35
Procailo, Alexander B.............29901 Ford Rd., Garden City
Proctor, J. Laurence.........................3815 Pelham, Dearborn
Proctor, Leonard R..................3815 Pelham Rd., Dearborn
Proctor, Lorne D...................Henry Ford Hospital, Detroit 2
Prokop, Frank P...................12740 S. Marrow St., Dearborn
Proskey, Aloysius J. (A)......16167 Glastonbury, Detroit 19
Proud, Russel F..............26151 Huron River Dr., Flat Rock
Prus, A. Michael..............................4160 John R St., Detroit
Prust, Frank W.........1536 David Whitney Blvd., Detroit 26
Prystowsky, S....................................1800 Tuxedo, Detroit 6
Przybylski, T. J............................20905 Greenfield, Southfield
Pugh, Howard C...............1553 Woodward Ave., Detroit 26
Pugliesi, Angelo.......................9489 E. Outer Dr., Detroit 13
Pugliesi, Benedetto................9489 E. Outer Dr., Detroit 13
Pugliesi, Frank J.....................20927 Kelly Rd., E. Detroit
Purcell, Frank H. (L)................10 Witherell St., Detroit 26
Puro, Henry E..............................1733 Trenton Dr., Trenton
Pursel, Stewart E.......307 David Whitney Bldg., Detroit 26
Purves, W. L.................................17595 Parkside, Detroit 21
Quennell, W. L. (A).................Highland Park Gen. Hosp.,
Highland Park
Quigley, Eugene H.........................111 Brentwood, Dearborn
Quigley, Wm. G.........................1075 Fisher Bldg., Detroit 2
Quinn, Edward L......................1141 Golfview, Birmingham
Quinn, Jarlath................14044 W. McNichols Rd., Detroit
Quinones, Rafael E...................17200 E. Warren, Detroit 24
Rabinovitch, Bella M...................20133 Marlowe, Detroit 35
Raby, Naim M....................................15830 Fort, Southgate
Rachmaninoff, N..........................Harper Hospital, Detroit 1
Radgens, Paul D...................Ford Motor Co., Highland Park
Ragheb, Maufid...................Detroit Receiving Hosp., Detroit
Rahm, Lambert P...........14411 E. Jefferson Ave., Detroit 15
Raiford, Frank P. (L)................................9310 12th, Detroit
Raiford, Frank P., Jr.................9107 12th Street, Detroit 6
Ralyea, Imbi...16645 Freeland, Detroit 35
Ramos, Herminio R.................9801 Conant, Hamtramck 12
Ramsey, Robt. H.........................3815 Pelham Rd., Dearborn
Randall, David S...........................3955 Fort St., Lincoln Park
Rapoport, Bernard..............................1800 Tuxedo, Detroit 6
Rapp, Seymour L...................5055 W. Outer Dr., Detroit 35
Raskin, Herbert A...................18510 Meyers Rd., Detroit 35
Rastello, Peter B. (R)....3295 West Shore Dr., Orchard Lake
Rattner, Wm. H.............1355 David Whitney Bldg., Detroit
Rau, Fredk. W.....................215 Professional Bldg., Detroit 1
Raven, Clara..............................400 E. Lafayette, Detroit 26
Ravitz, Louis A.........................23350 Thorncliff, Southfield
Ray, Kenneth J...........................28059 Elba Dr., Grosse Isle
Raynor, Harold F. (L)..................49 Virginia Pk., Detroit 2
Razi, Massoud.....................................1214 S. Wayne, Wayne
Read, Raymond........................Wayne State Univ., Detroit 7
Rebandt, Raymond W.................2615 W. Jefferson, Trenton
Rebuck, John W...................2799 W. Grand Blvd., Detroit 2
Redding, Lowell G.............1336 Southfield Rd., Lincoln Park
Reder, Benjamin..........17301 W. Eight Mile Rd., Detroit 35
Redfern, W. Earl..................2799 W. Grand Blvd., Detroit
Reed, H. Walter (L)..14447 W. Seven Mile Rd., Detroit 35
Reed, Ivor E.......................1553 Woodward Ave., Detroit 26
Reed, Joseph O., Jr...........................448 Lincoln, Detroit 30
Reed, Melvin L........................4160 John R. Street, Detroit 1
Rees, Howard C.......................15700 Mack Ave., Detroit 24
Reichert, Carl E.................18412 Mack Ave., Grosse Pointe
Reid, John G.......................1553 Woodward Ave., Detroit 26
Reid, Wesley G.....................3001 W. Grand Blvd., Detroit 2
Reidt, William U...............................1800 Tuxedo, Detroit 6
Reiff, Morris V...............................10241 Joy Rd., Detroit 4
Reinhard, Richard E.........7815 E. Jefferson Ave., Detroit 14
Reinsh, Ernest R.................600 Trailwood Path, Birmingham
Reisig, Robert O..............................20867 Mack, Detroit 36
Reisman, Nathan J.....15344 W. McNichols Rd., Detroit 35
Reisman, Saml. G...............1553 Woodward Ave., Detroit 26

Reive, David L. E.......................25447 Plymouth, Detroit 39
Remski, James E.........................29447 Ravine Dr., Livonia
Reno, George L..........................970 Fisher Bldg., Detroit 2
Rentenbach, Robt. F.........314 David Whitney Bldg., Detroit
Resto Soto, A. D.......................17644 W. Warren, Detroit 28
Reveno, Wm. S...................3001 W. Grand Blvd., Detroit 2
Reyner, Clarence E. (L).............10 Peterboro St., Detroit 1
Reynolds, Robt. M.......................856 Fisher Bldg., Detroit 2
Rezanka, Harold J............1553 Woodward Ave., Detroit 26
Rhoades, Francis P.........2414-16 Broderick Twr., Detroit 26
Rice, Harold B.............................10 Peterboro St., Detroit 1
Rice, Meshel...533 Coats Rd., Oxford
Richardson, Allan L. (R)..Naubinway
Rick, Paul J...12673 Joan, Detroit 5
Riddell, Wilfred A.............15420 Farmington Rd., Livonia
Rieckhoff, Geo. G. (L)...................14905 E. Jefferson Ave., Detroit 15
Rieden, James A.........................18053 Muirland, Detroit 21
Rieger, John B. (L).............................746 Pallister, Detroit 2
Rieger, Mary H. (L)......19285 Lucerne Dr., Highland Park
Riethmiller, Robt. F.........12444 E. Seven Mile Rd., Detroit
Rigler, Stanley P..................................1401 Rivard, Detroit 7
Rinaldo, Joseph, Jr...................Henry Ford Hosp., Detroit 2
Rinkel, Robert W.........................7319 Park Ave., Allen Park
Ritter, George...No address
Rivera, Emiliano, Jr.,............................1800 Tuxedo, Detroit 6
Rizzo, Paul.............260 Eastland Prof. Bldg., Grosse Pointe
Robb, Edward L. (L)........17380 Livernois Ave., Detroit 21
Robb, Herbert J...........................2706 Comfort, Birmingham
Roberts, Arthur J. (R)............859 Winchester, Lincoln Park
Roberts, George A...................7220 Gratiot Ave., Detroit 13
Robertson, Fredk. E.......................17000 W. Eight Mile Rd., Southfield
Robinson, Harold A.................10040 Yellowstone, Detroit 4
Robinson, Howard.........................953 Fisher Bldg., Detroit 2
Robinson, James H., Jr.......1553 W. Grand Blvd., Detroit 8
Robinson, Remus G..........................3751 31st St., Detroit 10
Rodin, Ernst A...........................951 E. Lafayette, Detroit 7
Roeglin, Orville F. F.................16800 E. Warren, Detroit 24
Roehl, Karl H.........................1800 Grindley Park, Dearborn
Rogers, Aaron Z.......................20451 Mack Ave., Detroit 36
Rogers, Geo. E. B.................8425 Twelve Mile Rd., Warren
Rogers, John T..........................29586 Five Mile Rd., Livonia
Rogers, Robert P...........................18980 Wyoming, Detroit 21
Rogoff, Abraham S.....17000 W. Eight Mile Rd., Southfield
Rohde, Paul C. (L)............12282 E. Outer Dr., Detroit 24
Roman, Stanley J.................15020 Michigan Ave., Dearborn
Romanski, Raymond............16001 W. 9 Mile Rd., Southfield
Ronayne, John J., Jr.....................16345 W. McNichols Rd., Detroit 35
Root, Fayette C...................719 New Center Bldg., Detroit 2
Rosbolt, James F.....................8505 Plymouth Rd., Detroit 4
Rosbolt, O. Paul, Jr.................8505 Plymouth Rd., Detroit 4
Rosefield, John L...........................65 W. Hancock, Detroit 1
Rosen, Harold M.............8620 W. McNichols Rd., Detroit 21
Rosen, Theodore S.................19340 Monte Vista, Detroit 21
Rosenbaum, Herbert....................18110 Muirland, Detroit 21
Rosenberg, Irvin K. (A)........................(Address Unknown)
Rosenbloom, Alvin B....................17555 Parkside, Detroit 21
Rosenfeld, L. S..................................1800 Tuxedo, Detroit 6
Rosenthal, Albert......................27855 Plymouth Rd., Livonia
Rosenthal, Louis H.............15401 W. McNichols, Detroit 35
Rosenthal, Saml...................................8844 Joy Rd., Detroit
Rosenwach, Felix F.....19149 W. Seven Mile Rd., Detroit 19
Rosenzweig, Norman.............6767 W. Outer Dr., Detroit 35
Rosenzweig, Saul...........................2542 W. Boston, Detroit 6
Ross, Charles V.............................7740 Da Costa, Detroit 39
Ross, Mervyn B............................9559 Greenfield, Detroit 27
Ross, Oscar A.......................................1800 Tuxedo, Detroit 6
Rotarius, Edward M...................Parke Davis Co., Detroit 32
Roth, Edward T. (L)............640 E. Grand Blvd., Detroit 7
Rother, Ina A. C.......................101 Chicago Blvd., Detroit 2
Rothwell, Walter S..............................2730 Chelsea, Trenton
Rottenberg, Coleman M. J............13419 Fenkell, Detroit 27
Rottenberg, E. N.......20725 W. Seven Mile Rd., Detroit 19
Rottenberg, Leon.................13419 Fenkell Ave., Detroit 27
Roubeck, William........17000 W. Eight Mile Rd., Southfield
Rowda, Michael S.....................7 Cambridge, Pleasant Ridge
Rowe, Jos. J., Jr......................................401 N. Brady, Dearborn
Roy, L. James..........................1210 Kales Bldg., Detroit 26
Royer, Richard R.............18101 E. Warren Ave., Detroit 24
Rubinoff, William........21415 W. Eight Mile Rd., Detroit 19
Ruble, Paul E............1139 David Whitney Bldg., Detroit 26
Rudner, Earl J. (A)...............................18027 Coyle, Detroit
Ruedemann, Albert D.......1553 Woodward Ave., Detroit 26
Ruedemann, Albert D., Jr..................1553 Woodward Ave., Detroit 26
Rueger, Milton J...........717 Dav. Whitney Bldg., Detroit 36
Rueger, Ralph C..............9149 E. Jefferson Ave., Detroit 14
Ruel, Richard E.........1515 David Whitney Bldg., Detroit 26
Ruiz, Luis C...No address
Runge, Edward F. (A)..........................8295 39th Ave. N, St. Petersburg, Florida
Rupe, Clarence E................2799 W. Grand Blvd., Detroit 2
Rupp, Jacob R. (L)....................247 Cass Lake Rd., Pontiac
Rupprecht, Emil F...................15901 Greenfield Rd., Detroit
Rush, Desmond K.....1429 David Whitney Bldg., Detroit 26
Ruskin, Robert L..........................Sinai Hospital, Detroit 35
Ruskin, Saml. H. (L)................1112 Kales Bldg., Detroit 26
Russanow, Georg.........................400 E. Lafayette, Detroit 26
Russell, Henry N., Jr................15101 Southfield, Allen Park
Rutzen, Arthur C...............20211 Greenfield Rd., Detroit 35
Ruzumna, Richard A. (A)................Receiving Hosp., Detroit
Ryan, James M.........................16888 Greenfield, Detroit 35
Ryan, William D. (R)..........Box 10931, St. Petersburg, Fla.
Sabbagh, Enrique................2605 W. Grand Blvd., Detroit 8
Sack, Anthony G..................18230 Grand River, Detroit 23
Sadi, Lutfi M................................10 Peterboro St., Detroit 1
Sadler, Henry H., Jr.....12 Tamalpais Rd., Belvedere, Calif.
Sadzikowski, Jos. T...........1390 Kinmore, Dearborn Heights
Sage, Bernard A............................1013 Haigh St., Dearborn
Sager, Edward L.....................13902 Gratiot Ave., Detroit 5
St. Amour, Hector J...25515 Blossingham Dr., Dearborn Hts.
St. Louis, Rene J. (L)....................10909 W. Jefferson Ave., River Rouge 18
Sakorraphos, S. N. (L)................1346 Broadway, Detroit 26
Sakwa, Saul.............................17000 W. Eight Mile, Southfield
Salan, Lacy J...................................995 S. Main St., Plymouth
Salchow, Paul T...................Herman Kiefer Hosp., Detroit 2
Salem, Edward S.........22420 Twyckingham Way, Southfield
Salhaney, Mitchell........................15252 Levan Rd., Livonia
Sall, Caroline D...6246 Chase, Dearborn
Sallee, William T..........................17000 W. 8 Mile, Southfield
Saltzstein, Harry C. (L)..........850 Whitmore Rd., Detroit 3
Salvaggio, A. T.......426 Eastland Prof. Bldg., Harper Woods
Samberg, L. Carl....................1210 Kales Bldg., Detroit 26
Sand, Harry H...................................24110 Oxford, Dearborn
Sandberg, Hershel........................19207 Schaefer, Detroit 35
Sander, Irvin W. (R)...........................1073 Stratford Lane, Bloomfield Hills
Sanders, Alexander W...................16350 Hamilton, Detroit 3
Sanderson, Alvord R. (L)......................978 Pemberton Rd., Grosse Pointe 30
Sandler, Nathaniel..................76 W. Adams Ave., Detroit 26
Sapala, Andrew................21471 Cherry Hill Road, Dearborn
Saraf, Leo B..............................14540 E. Warren, Detroit 15
Sargent, Douglas A.....................................816 Grand Marais, Grosse Pointe Park
Sargent, Richard C...................17357 Fenkell St., Detroit 27
Sargent, William R....................17357 Fenkell St., Detroit 27
Sarracino, John B. (A)......................34th Med. Gen. Hosp., APO 58, New York, N. Y.
Sauk, John J......................302 W. McNichols Rd., Detroit 3
Saunders, Gene A.........................33521 6 Mile Rd., Livonia
Sauter, Simon H. (L)..........1082 E. Grand Blvd., Detroit 7
Savignac, Eugene M.................Holy Cross Hosp., Detroit 34
Sawdyk, Daria H...................7012 Michigan Ave., Detroit 10
Sazye, Joseph S..............................22101 Moross Rd., Detroit
Scarano, Domenico........12950 W. Chicago Blvd., Detroit 28
Scarney, Herman D.............3011 W. Grand Blvd., Detroit 2
Schaefer, H. C...........................7815 E. Jefferson, Detroit 14
Schaefer, Robt. L. (A)..........76 W. Adams Ave., Detroit 26
Schaefer, Robt. L., Jr.....................74 W. Adams, Detroit 26
Schaeffer, J. N..261 Brady, Detroit 1
Schaeffer, Martin............18275 Warrington Dr., Detroit 21
Schakne, Norman..........................669 Fisher Bldg., Detroit 2
Schane, David A...........................19159 Berkeley, Detroit 21
Schatten, Ivan C.................2201 E. Jefferson Ave., Detroit 7
Scheinberg, S. R.................5388 Park Ave., Memphis, Tenn.
Schembeck, Isaac S. (L)....1553 Woodward Ave., Detroit 26

Scherer, Robert A.........................470 Fisher Bldg., Detroit 2
Schidlowsky, Oleg P...........10531 Farmington Road, Livonia
Schiller, Arthur E. (L)......1553 Woodward Ave., Detroit 26
Schillinger, H. K. (A)...........................300 Berkley, Dearborn
Schirack, Raymond D. (R)..Luzerne
Schkloven, Norman................20051 Warrington, Detroit 21
Schlafer, Nathan H.....................10 Witherell St., Detroit 26
Schlesinger, Henry............13534 Woodward Ave., Detroit 3
Schmaltz, John D.....1701 David Whitney Bldg., Detroit 26
Schmidt, Generva F.................1074 Vernier Rd., Detroit 36
Schmidt, George J.......................7106 Park Ave., Allen Park
Schmidt, Harry E...........................667 Fisher Bldg., Detroit 2
Schmidt, Johann.........................7815 E. Jefferson, Detroit 14
Schmidt, Klaus P..........................871 Fisher Bldg., Detroit 2
Schmidt, Werner F...................1807 Stroh Bldg., Detroit 26
Schmier, Burton L. (A)............20051 Litchfield, Detroit 21
Schmitt, Norman L...10127 W. McNichols Road, Detroit 21
Schneck, Robt. J.................1553 Woodward Ave., Detroit 26
Schneider, Chas. L...............22148 Michigan Ave., Dearborn
Schneider, Curt P..........................655 Fisher Bldg., Detroit 2
Schoenfield, Gilbert D.....................8830 W. McNichols Rd., Detroit 21
Scholdager, Rolf H...........................1800 Tuxedo, Detroit 6
Schooten, Sarah S...............................13700 Woodward Ave., Highland Park 3
Schorer, Calvin E..........................951 E. Lafayette, Detroit 7
Schroeder, Carlisle F...........26505 E. River Rd., Grosse Isle
Schroeder, Gisela..............22408 Park Lane, St. Clair Shores
Schroeder, Heinz R.............1941 Hawthorne Blvd., Dearborn
Schuchter, S. L....................................1800 Tuxedo, Detroit 6
Schulte, Carl H. (L)..............28 W. Adams Ave., Detroit 26
Schultz, Clarence H...................23100 Cherry Hill, Dearborn
Schultz, Ernest C. (L)......1553 Woodward Ave., Detroit 26
Schuman, Bernard M...........Henry Ford Hospital, Detroit 2
Schwartz, Benj.....................275 W. Grand Blvd., Detroit 16
Schwartz, Harold A.................7605 Puritan Ave., Detroit 38
Schwartz, Louis A. (A)........P.O. Box 315, Rockport, Mass.
Schwartz, Oscar D.......7421 W. Seven Mile Rd., Detroit 21
Schwartzberg, J. A.....................19445 Plymouth, Detroit 28
Schwarz, Frank W.......................23100 Cherryhill, Dearborn
Schweigert, C. F..................10627 Cadieux Rd., Detroit 24
Schwimmer, Benjamin..................8811 John C. Lodge Bldg., Detroit 2
Schwocho, Niles H.......................7106 Park Ave., Allen Park
Sciarrino, Stanley V. (L)....15388 Livernois Ave., Detroit 38
Scott, Marrion U.....................20170 Mack Ave., Detroit 36
Scott, Robert J.........26075 Woodward, Huntington Woods
Scott, Wm. J. (L)....20170 Mack Ave., Grosse Pointe Woods
Screen, Raymond J.....18520 W. Seven Mile Rd., Detroit 19
Secord, Eugene W. (A)..........660 Whitmore Rd., Detroit 21
Segal, Andrew E.................19481 Livernois Ave., Detroit 21
Segar, Laurence F.................998 Church St., Ventura, Calif.
Segel, Nathan P..............................19100 Manor, Detroit 21
Seibert, Alvin H. (L)..................................1180 Bedford Rd., Grosse Pointe Park 30
Seiferlein, A. L...................1553 Woodward Ave., Detroit 26
Seim, Elmer J................................Grace Hospital, Detroit 1
Seitam, Karl..........................10149 Michigan Ave., Dearborn
Selbst, Ronald A.........26339 Woodward, Huntington Woods
Self, Wm. G...................20861 Mack Ave., Grosse Pointe 36
Selim, Mahmaud M...........2141 E. Jefferson Ave., Detroit 7
Sellers, Chas. W. (L)......18545 Schoolcraft Ave., Detroit 23
Sellers, Graham A. (A)................10535 W. Seven Mile Rd., Detroit 21
Seltzer, Joseph.............................20905 Greenfield, Southfield
Selzer, Isidore...................................4811 John R St., Detroit 1
Senecoff, Stephen D...................16800 Greenfield, Detroit 35
Sepetys, Povilas...........................25466 Clairview, Dearborn 6
Seski, Arthur G..........................1069 Fisher Bldg., Detroit 2
Severyn, Fred R.............................15830 Fort St., Southgate
Sewell, Geo. (L)..............31801 Arlington Dr., Birmingham
Sewell, Guy W...............17751 East Warren Ave., Detroit 24
Shafadeh, Asghar....................28303 Joy Road, Garden City
Shafarman, Eugene M.................5320 John R St., Detroit 2
Shaffer, Jos. H..........................2401 Radnor Dr., Birmingham
Shaffer, Loren W. (R)......6040 Wildrose Lane, Port Huron
Shafter, Royce R...........................1188 Puritan, Birmingham
Shams Avari, Parviz....................27584 Schoolcraft, Livonia
Shanoski, Stanley J......................1910 David Broderick Twr., Detroit 26
Shapiro, Reuben I.................22341 W. 8 Mile Rd., Detroit
Shaptini, Elias A......................1 Woodward Ave., Detroit 26
Shargel, Geo. M. J..............................1800 Tuxedo, Detroit 6
Sharp, Elwood A. (A)..........633 Neff Rd., Grosse Pointe 30
Sharpe, Wm. D...........24621 W. McNichols Rd., Detroit 19
Sharrer, Chas. H.............................1133 Grayton, Detroit 30
Shea, Francis P.............................Harper Hospital, Detroit 1
Shecter, Harry..........................2200 E. Grand Blvd., Detroit
Sheehan, Irene C..........................15520 Garfield, Allen Park
Sheehan, Shelia..................Det. Receiving Hosp., Detroit 26
Shekerjian, Armen........27640 Morningside, Lathrup Village
Shelden, Warren E.....14215 W. McNichols Road, Detroit 35
Shelfoon, Delores J.........................1660 Oakman Blvd., A 3, Detroit 38
Sherman, Marvin................20101 James Couzens, Detroit 35
Sherman, W. LaRue (L).............10 Peterboro St., Detroit 2
Sherman, Wm. L., Jr. (A)................201 E. Kirby, Detroit 1
Sherrin, Edgar R.................19021 W. McNichols, Detroit 19
Shevin, Frederick F.....................18450 Livernois, Detroit 21
Shewchuk, A. P.............................7300 Allen Rd., Allen Park
Shields, Wm. L.....................................510 Hildale, Detroit 3
Shiffman, Milton M...............Mt. Sinai Hospital, Detroit 35
Shifrin, Peter G.........................20211 Greenfield, Detroit 35
Shin, Eon..................................1800 Tuxedo Ave., Detroit 6
Shiovitz, Louis.......................5419 Michigan Ave., Detroit 10
Shipton, Waldo H. (A)..........General Delivery, Naples, Fla.
Shlain, Benj..................................19280 Berkeley, Detroit 21
Shors, Clayton M....................19635 Mack Ave., Detroit 35
Shortz, Gerald (A)............920 15th Place, Vero Beach, Fla.
Shreve, Alfred J......................4520 Firestone Ave., Dearborn
Shuey, John M.............................17198 Oak Dr., Detroit 21
Shufro, Arthur S...................28585 Rivercrest Dr., Southfield
Shulman, Herschel A...................207 Northland Med. Bldg., Southfield
Shumaker, Edward J...........................75 Lothrop, Detroit 36
Siddall, Roger S. (L)..........3011 W. Grand Blvd., Detroit 2
Sieber, Edward H.......................6650 Greenfield Rd., Dearborn
Siebert, William E.......23023 Orchard Lake Rd., Farmington
Siefert, John L. (R)....................P.O. Box 601, Jupiter, Fla.
Siegel, Henry............................19720 Chesterfield, Detroit 21
Siero, Jose M...............................9105 Van Dyke, Detroit 13
Sievers, Lorraine A.....1457 David Whitney Bldg., Detroit 26
Sigler, John W..........................Henry Ford Hospital, Detroit
Sill, Jacob A.................20861 Mack Ave., Grosse Pte. Woods
Siller, John J.......................17000 W. 8 Mile Rd., Southfield
Sillery, Robt. J.....................460 Lakeland, Grosse Pointe 30
Sills, Richard D.........................19321 Greenfield, Detroit 35
Silvarman, Israel Z.............9105 Van Dyke Ave., Detroit 13
Silver, Donald F...........................467 Fisher Bldg., Detroit 2
Silver, Israel W.......................20000 W. Chicago, Detroit 28
Silver, Marvin D. (A)........Detroit Receiving Hosp., Detroit
Silver, Robert R...............................20188 Wakefield, Detroit
Silverman, Maurice M...................17301 W. Eight Mile Rd., Detroit 35
Silverman, Max....................2240 W. Grand Blvd., Detroit 8
Silverstein, M. E...........952 Dav. Whitney Bldg., Detroit 26
Silverstein, O. D.................17000 W. 8 Mile Rd., Southfield
Silvestre, Mario S...........................19600 Van Dyke, Detroit
Simard, J. E. Henri................8220 E. McNichols, Detroit 34
Simmons, Donald R......................529 Fisher Bldg., Detroit 2
Simon, Heinz G..............................12206 Morang, Detroit 24
Simpson, David F......................................(Address Unknown)
Simpson, Gordon E.........18101 E. Warren Ave., Detroit 24
Simson, Clyde B...............................951 E. Lafayette, Detroit
Singer, Floyd W....................13530 Michigan Ave., Dearborn
Sippola, Geo. W. (L)..........13603 LaSalle Blvd., Detroit 38
Sivak, B. J...........................24665 Santa Barbara, Southfield
Sklar, Manuel..............................18400 Schaefer Rd., Detroit
Skully, Edward J..........................14000 Linnhurst, Detroit 5
Sladen, Frank J. (L)............Henry Ford Hospital, Detroit 2
Slahetka, Vincent E.............4162 Pardee, Dearborn Heights
Slaughter, Fred M. (L)..............2562 Ferry Park, Detroit 8
Slazinski, Leo W. (L)..........7618 Michigan Ave., Detroit 10
Slevin, John G.........1132 Whittier Ave., Grosse Pointe Park
Sliwin, Edward P.......................13244 W. Warren, Dearborn
Slusky, Jos....................................854 Fisher Bldg., Detroit 2
Sly, Robt. F.......................2101 Monroe Blvd., Dearborn 8
Small, Harvey O. J.......................Elliott Gen. Hosp., Detroit
Small, Henry......................15300 W. McNichols Rd., Detroit
Small, John...................................19223 Conant, Detroit 34
Smathers, Homer M.............17620 W. McNichols, Detroit 35
Smathers, Ward M.............17620 W. McNichols, Detroit 35
Smeck, Arthur R. (L)..........1036 Waterman Ave., Detroit 9
Smiggen, James J.......................19647 Joy Road, Detroit 28
Smith, Andrew J................................2950 Puritan, Detroit 38
Smith, Claude A. (L).......................7 Adams Lane, Dearborn

Smith, Douglas H.....................10151 Michigan, Dearborn 2
Smith, F. Janney (L)....................................352 Moselle Pl., Grosse Pointe Farms
Smith, Henry L.............16401 Grand River Ave., Detroit 27
Smith, J. Allen........................14140 Puritan Ave., Detroit 27
Smith, Richard H..............................5050 Joy Road, Detroit 4
Smith, Richmond W., Jr.....2799 W. Grand Blvd., Detroit 2
Smith, Roger F.........18755 Wilshire Ave., Lathrup Village
Smith, W. Pierce..................Henry Ford Hospital, Detroit 2
Smolenski, John J...................13815 Puritan Ave., Detroit 27
Smyka, Stanley M.......................15731 Glenwood, Detroit 5
Snider, Eugene A.......................20905 Greenfield, Southfield
Snider, Thomas H..........................V.A. Hospital, Dearborn
Snoke, Edwin C.................................2901 West Rd., Trenton
Snow, Linwood W........................508 W. Main St., Northville
Snyder, Richard J...................33433 Six Mile Road, Livonia
Sobel, Robt. A.............................18980 Wyoming, Detroit 21
Soble, Allen R...........................18241 Greenfield, Detroit 35
Soderberg, Ralph B.........7815 E. Jefferson Ave., Detroit 14
Soifer, Sidney..................................Sinai Hospital, Detroit 35
Sokol, Wm. M...................15800 W. McNichols, Detroit 35
Sokolov, Raymond A...........3011 W. Grand Blvd., Detroit 2
Sokolowski, A. H...................5550 Mitchell Ave., Detroit 11
Solberg, Lincoln E.........................2021 Monroe, Dearborn
Soller, Alex S............................19309 Greenfield, Detroit 35
Solomon, A. B.............................9559 Greenfield, Detroit 27
Solomon, Robert J.....................15101 Southfield, Allen Park
Somerville, Thos. H.................36475 Five Mile Rd., Livonia
Sonda, Lewis P. (R)............20284 Orangelawn, Detroit 26
Sonda, Lewis P., Jr.........................5132 Allen Rd., Allen Park
Songe, Robert A.........................Oakwood Hospital, Dearborn
Sorock, Milton L..........................19467 Livernois, Detroit 21
Sosa, Carlos M. A.........10824 Talbot St., Huntington Woods
Sowa, Elizabeth C. (A)......Detroit Receiving Hosp., Detroit
Speck, Carlos C...........................6742 Park Ave., Allen Park
Spector, Maurice J.................12938 E. Jefferson, Detroit 15
Sperry, Frederick L. (A)........490 Arlington, Berkeley, Calif.
Sphire, Raymond D......................4160 John R St., Detroit 1
Spiegelmann, H. L.......................15361 Plymouth, Detroit 27
Spiro, Adolph S..............................13240 Harper, Detroit 13
Spiwak, Bertram J.............7407 Cathedral Dr., Birmingham
Springborn, Benj. R. (L)..................15818 E. Warren Ave., Detroit 24
Sprunk, Carl J...................2900 Oakwood Blvd., Melvindale
Spurrier, Ethelbert,............1553 Woodward Ave., Detroit 26
Squires, Walter M. (R)...............................1616 S. 28 Ave., St. Petersburg, Fla.
Stalker, Hugh (R)....Cottage Hospital, Grosse Pointe Farms
Stamell, Benjamin B.....17000 W. Eight Mile Rd., Southfield
Stamell, Meyer....................14634 Greenfield St., Detroit 27
Stanton, James M. (L)..........1001 Mutual Bldg., Detroit 26
Stanton, Myron R........7441 W. Seven Mile Road, Detroit 21
Stapleton, Wm. J., Jr. (L)......201 E. Kirby Ave., Detroit 2
Staricco, Renato..........................3783 Fort St., Lincoln Park
Staryk, Steven E.................1010 N. Oxford Rd., Detroit 36
Statzer, Darrell E.........................955 Fisher Bldg., Detroit 2
Staub, Howard P.....................37625 Michigan Ave., Wayne
Staudt, Louis W............................1201 Pilgrim, Birmingham
Stearns, Alexander B..........................7430 Second, Detroit 2
Stebbins, Chas E.........705 Northland Med. Bldg., Southfield
Steepe, Chas. A. D.........20867 Mack, Grosse Pointe Woods
Stefani, Andrew E.....................1701 N. Renaud, Detroit 36
Stefani, Ernest L.........18455 Jas. Couzens Hwy., Detroit 35
Stefani, Raymond T.......................13526 Stoepel, Detroit 38
Stein, Albert H.....................19334 San Juan Dr., Detroit 21
Stein, Emory................................13115 Woodward, Detroit 3
Stein, Harvey S.....................22341 W. 8 Mile Rd., Detroit
Stein, Saul C...............................23105 Van Dyke, Van Dyke
Steinbach, A. L.......320 Merriweather Rd., Grosse Pointe 36
Steinberger, E. J. (L).......................6402 W. Fort, Detroit 9
Steiner, Fredk. B...........................7675 Ridge Rd., Plymouth
Steiner, S. D........................3044 W. Grand Blvd., Detroit 2
Steinhardt, Milton J.....................10720 W. Seven Mile Rd., Detroit 21
Stellhorn, Chester E.....................12900 W. Seven Mile Rd., Detroit 35
Stellhorn, Mary C. (A)..........16616 Mack Ave., Detroit 24
Stempel, Edward M.............18324 Fairfield Ave., Detroit 21
Sterba, Richard F.............18228 Mack Ave., Grosse Pointe
Stern, Edward A.....................12710 Dexter Blvd., Detroit 38
Stern, Joseph W.................15101 W. Seven Mile, Detroit 35
Stern, Julian................15121 W. McNichols Road, Detroit 35
Stern, Leonard H.........................19200 Aften Rd., Detroit 3
Stern, Louis D. (L)............1553 Woodward Ave., Detroit 26
Stern, Sheldon D.......................802 Mutual Bldg., Detroit 26
Sternhill, Vernon...................................1800 Tuxedo, Detroit 6
Stevens, Chas. H...................Med. Concourse NC, Southfield
Stevenson, Chas. S.................411 Professional Bldg., Detroit
Stevenson, Lee B.......................Henry Ford Hosp., Detroit 2
Stewart, Lula B.........................8633 Dexter Blvd., Detroit 6
Stewart, Maitland N., Jr...........20905 Greenfield, Southfield
Stewart, Marjorie (A)........................581 Golfcrest, Dearborn
Stewart, Robert M.................10933 Farmington Rd., Livonia
Stiefel, Danl. M.............1563 Dav. Whitney Bldg., Detroit 26
Stillwater, Karl...............................18221 Pennington, Detroit 21
Stith, Dwight E...................................505 Owen St., Detroit 2
Stobbe, Godfrey D.........................Grace Hospital, Detroit 1
Stock, Thomas B.......................19610 Middlesex, Southfield
Stocker, Lawrence L.................7310 W. 7 Mile Rd., Detroit
Stocker, Marvin L.......................16401 Grand River, Detroit
Stockwell, Benj. W.............1553 Woodward Ave., Detroit 1
Stokfisz, Thaddeus.........................7012 Michigan, Detroit 10
Stoller, Raymond..........25210 Grand River Ave., Detroit 40
Stone, Sidney L.............14620 E. Seven Mile Rd., Detroit 5
Stoyka, Michael R.................911 Ballantyne Rd., Detroit 34
Straith, Richard E.................2605 W. Grand Blvd., Detroit 8
Strand, Martin E.................22400 Cherry Hill, W. Dearborn
Strauss, Ernest G....................................1024 Blairmoor St., Grosse Pointe Woods
Stricker, Henry D.........................5624 W. Fort St., Detroit 9
Strickler, D. T., Jr...............22231 W. Outer Dr., Dearborn
Strickroot, Fred L.....................3800 Bishop Rd., Detroit 24
Stronski, G. E..................................9901 Whittier, Detroit 24
Stryker, Joan C......................21604 E. River Rd., Grosse Ile
Stryker, Walter A............................P.O. Box 31, Wyandotte
Stubbs, Clayton T. (R)............133 S. Walnut, Mt. Clemens
Stubbs, Harold W. (L)......13930 Woodward Ave., Detroit 3
Subrin, Mayer.............................19230 Canterbury, Detroit 21
Suen, Irene T. S.................7900 Joseph Campu, Detroit 34
Sugar, David I. (L).......................18104 Oak Dr., Detroit 21
Sugar, H. Saul......................18140 San Juan Dr., Detroit 21
Sugarman, Marcus H.........15201 W. McNichols, Detroit 35
Sugayan, Norberto A.............Wayne Co. Gen. Hosp., Eloise
Sullivan, Hugh A. (L)......1553 Woodward Ave., Detroit 26
Sullivan, Paul J.........26711 Woodward, Huntington Woods
Sullivan, Thomas M.....................951 E. Lafayette, Detroit 7
Sultzman, L. Carl......55 Vendome, Grosse Pointe Farms 36
Summers, Wm. A..............1553 Woodward Ave., Detroit 26
Summers, Wm. S. (L).........................524 S. Lakeside Drive, Lake Worth, Fla.
Sutherland, Jacob M. (L)..............8900 E. Jefferson, Detroit
Suwinski, Raymond H.......9801 Conant St., Hamtramck 12
Swan, Donald C...........17000 W. Eight Mile Rd., Southfield
Swan, Lionel F...................................9245 Mack, Detroit 14
Swanson, Carl W...........................936 Alter Rd., Detroit 15
Swanson, Robt. G.................17800 E. 8 Mile Rd., Detroit 36
Swartz, Fred G., Jr.....1329 David Whitney Bldg., Detroit 26
Sweeny, Donald N., Jr.............8445 E. Jefferson, Detroit 14
Switzer, Bertrand C. (R).............................1862 Riverside, Columbus 21, Ohio
Syphax, Charles S.........................1819 E. Davison, Detroit 3
Szappanyos, G. G......................16001 9 Mile Rd., Southfield
Szilagyi, D. Emerick............Henry Ford Hospital, Detroit 2
Szladek, Frank J.............4045 W. Jefferson Ave., Ecorse 29
Szmigiel, Alex J.................................20060 Kelly, East Detroit
Taber, Rodman E.....................Henry Ford Hosp., Detroit 2
Tactac, Albert J............................15244 Middlebelt, Livonia
Talbot, Frank G......................................1365 Cass, Detroit 26
Tallant, Edward J.....................18041 Greenfield, Detroit 35
Talley, Robt. W.........................Henry Ford Hosp., Detroit 2
Talmers, Fredk. N...............................V.A. Hospital, Dearborn
Tamblyn, E. J. (L)..................737 Marlborough, Detroit 15
Tanay, Emanuel.............................861 Fisher Bldg., Detroit 2
Tanner, Natalia M.............8401 Woodward Ave., Detroit 2
Tapert, Julius C.....................888 Chalmers Ave., Detroit 15
Tarpinian, Harry..................10955 Farmington Rd., Livonia
Tasker, Helen E.......................76 W. Adams Ave., Detroit 26
Tassie, Ralph N. (L)..............15000 Gratiot Ave., Detroit 5
Tatelis, Gabriel A.................1011 E. Grand Blvd., Detroit 7
Tatelman, Maurice.....................1321 Joliet Place, Detroit 26
Taurence, Wm. H........................1860 Ford Ave., Wyandotte
Taylor, Amos, III...............................301 E. Kirby Detroit 2
Taylor, Ivan B...30 N. Edgewood Dr., Grosse Pointe Shores
Taylor, Junius L.................1566 W. Grand Blvd., Detroit 6
Taylor, Michael A. (A)..............Receiving Hospital, Detroit

Taylor, Nelson M.....215 Dean Lane, Grosse Pointe Park 36
Taylor, Richard A.....28 W. Adams St., Detroit 26
Taylor, Ward M.....2201 E. Jefferson Ave., Detroit 7
Taylor, Wm. V.....17200 E. Warren, Detroit 24
Tazzioli, Henry A.....21970 Moross Rd., Detroit 36
Tear, Malcolm J. J.....862 W. McNichols Rd., Detroit 3
Teitelbaum, Myer.....18510 Meyers Rd., Detroit 35
Tenaglia, Thos. A.....3180 Fort St., Lincoln Park
Teves, Manuel L.....13020 Mack, Detroit 15
Texter, Elmer C. (L).....7457 Gratiot Ave., Detroit 13
Thal, Alan P.....687 Balfour, Detroit 36
Thomas, Alfred E.....73 E. Palmer, Detroit 2
Thomas, Blanche M.....6535 Allen Rd., Allen Park
Thomas, Leon D.....3019 West Warren, Detroit 8
Thomas, L. Murray.....801 David Whitney Bldg., Detroit 26
Thompson, Arthur L.....12632 Dexter, Detroit 38
Thompson, Hugh O.....6014 W. Fort St., Detroit 9
Thompson, Wm. A. (R).....12632 Dexter, Detroit 38
Thomson, Danl. C.....2934 Biddle Ave., Wyandotte
Thorley, Lawrence.....Grace Hosp., Detroit
Thornton, Jerry A.....525 Visger Rd., Ecorse 29
Thosteson, G. C.....1139 David Whitney Bldg., Detroit 26
Thumann, Robt. C.....20045 Mack Ave., Grosse Pointe Woods
Thumim, Sadie.....15306 Joy Rd., Detroit 28
Timma, Richard J.....16401 Grand River Ave., Detroit 27
Ting, Yoeh Ming.....16024 Stratford Dr., Southfield
Tkaczuk, Dmytro.....10345 Joseph Campau, Detroit 12
Toal, Robert E.....20953 Grand River, Detroit 19
Todoroff, Theodore G.....22146 Ford Rd., Dearborn 6
Tolbert, Vassal G.....3461 W. C. Chrysler Exp., Detroit 1
Tomsu, Chas. L. (L).....16521 Westmoreland Rd., Detroit 19
Torp, Raymond T.....722 Notre Dame, Grosse Pointe 30
Torres, Estelle P.....3985 Caniff, Hamtramck 12
Torres, Raul M., Jr.....3985 Caniff St., Hamtramck 12
Tourkow, Lawrence P.....3290 Sherbourne Rd., Detroit 21
Tourney, Garfield.....Lafayette Clinic, Detroit 7
Townsend, Frank M., Jr.....1055 Trumbull, Detroit 16
Tracey, John M.....15317 W. McNichols, Detroit 35
Tracy, Edward G.....3411 Evaline St., Detroit 12
Trader, Kenneth N.....3001 W. Grand Blvd., Detroit 2
Treisman, E. J.....15105 W. Seven Mile Rd., Detroit
Tremain, Harold L.....15475 Ashton, Detroit 23
Triska, Franz K.....12444 E. Seven Mile Rd., Detroit 5
Troester, Geo. A.....81 E. Kirby, Detroit 2
Trombino, James F. V.....8625 Marygrove Dr., Detroit 21
Trotsky, Martin B.....7411 Third Ave., Detroit 2
Truba, Paul K.....22770 Kelly Rd., East Detroit
Trudeau, John M.....14200 Puritan, Detroit 21
Trudgen, Paul E.....1224 Beechmont, Dearborn
Trunsky, Ronald E.....Sinai Hospital, Detroit 35
Trupiano, Samuel.....420 Eastland Prof. Bdg., Detroit 36
Trythall, S. W.....Box 33, Orchard Lake
Tseng, George T. C.....3419 Sophia St., Wayne
Tukel, Floyd S.....2021 Monroe, Dearborn
Tulloch, John A.....1807 Dav. Whitney Bldg., Detroit 26
Tulloch, John C.....1040 Dav. Whitney Bldg., Detroit 26
Tupper, Roy D. (L).....15101 W. 7 Mile Rd., Detroit 19
Turcotte, Vincent J. (A).....Presque Isle
Turkel, Henry.....8000 W. Seven Mile Rd., Detroit 21
Turman, Ramon D.....25210 Grand River, Detroit 40
Turnbull, Jack V.....22340 Michigan Ave., Dearborn
Turner, Edward T.....5050 Joy Rd., Detroit 4
Turner, Rachel E.....3113 Evergreen, Royal Oak
Turner, Robert R.....2841 Monroe Blvd., Dearborn
Uddyback, Odie T.....8401 Woodward Ave., Detroit 2
Ujda, Chester J.....32126 Woodbrook, Wayne
Ulmer, Arthur A.....79 Greenbriar, Grosse Pointe Shores
Ulrich, Elmer E.....5596 Eastlawn, Detroit 13
Ulrich, John L.....23100 Cherry Hill, Dearborn
Ulrich, Willis H.....22365 Grand River Ave., Detroit 19
Unkefer, Wm. T.....15800 W. McNichols Rd., Detroit 35
Usndek, Harold E.....18485 Mack Ave., Detroit 36
Vaitas, Otonas.....10531 Farmington Rd., Livonia
Vaitkevicius, V.....4160 John R St., Detroit 1
Valdesuso, R. I.....14763 Rossini Drive, Detroit 5
Valdes-Valenzuela, E.....Oakwood Hospital, Dearborn
Vale, Clair F. (R).....2615 Via Tuscany, Winter Pk., Fla.
Van Arsdale, Wm. L. (A).....1000 Chung Cheng Rd., Taipei, Taiwan
Van Becelaere, L. A.....15830 Fort, Southgate
Vanden Berg, H. J., Jr.....1553 Woodward Ave., Detroit 26
Vander, Seymour A.....22341 W. 8 Mile Rd., Detroit
Van Eck, James E.....11540 Morang Drive, Detroit
Van Hoek, Donald E.....20323 Mack, Grosse Pte. Wds.
Van Raaphorst, L. F.....861 Monroe, Dearborn
Van Riper, Steven L.....1490 Iroquois, Detroit 14
Van Slyck, E. J.....Henry Ford Hosp., Detroit 2
VanValzah, Henry J.....Ford Mtr. Co., Miller Rd., Dearborn
Vardon, Edward M.....12897 Woodward Ave., Highland Park 3
Vasu, Vasile O.....4829 Woodward Ave., Detroit 1
Vaughan, Clarence B.....Grace Hospital, Detroit
Veling, William F.....3001 W. Grand Blvd., Detroit 2
Vence, Carlos A.....Saratoga Hospital, Detroit
Vera, Ramon W.....20905 Greenfield, Southfield
Vincent, Charles C.....2424 Puritan, Detroit 38
Vincent, John W.....22146 Ford Rd., Dearborn
Vipond, W. Fraser.....15398 Gratiot Ave., Detroit 5
Viscomi, Geo. J.....23422 Ford Rd., Dearborn
Visscher, Donald W.....12922 W. Warren, Dearborn
Vokes, Milton D. (L).....10182 Gratiot Ave., Detroit 13
Vonberg, Vollrad J.....14540 Warren, Detroit 24
Vonder Heide, Elmore C.....17190 Strathmoor, Detroit 35
Vorwald, Arthur J.....1401 Rivard St., Detroit 7
Vossler, Albert E.....1553 Woodward Ave., Detroit 26
Wagenberg, Harold R.....20514 Bentler, Detroit 19
Waggoner, Lyle G.....404 Dav. Whitney Bldg., Detroit 26
Wagner, John R.....474 Fisher Bldg., Detroit 2
Wagoner, George F.....14300 W. McNichols Rd., Detroit 35
Wahl, Richard A.....17555 Jas. Couzens Hwy., Detroit 35
Wainger, Max J.....15105 W. 7 Mile Rd., Detroit 35
Wainstock, Michael A.....621 David Whitney Bldg., Detroit 26
Wakeman, Everal M.....23100 Cherry Hill, Dearborn
Waldbott, Geo. L.....2930 W. Grand Blvd., Detroit 2
Walker, Frank B., II.....1305 Berkshire Rd., Grosse Pte.
Walker, Geo. L.....7815 E. Jefferson Ave., Detroit 14
Walker, Robert M.....2101 Monroe, Dearborn
Walkowiak, Robt. G.....76 W. Adams Ave., Detroit 26
Wallace, Silas W. (L).....7815 E. Jefferson Ave., Detroit 14
Wallaert, Albert A. J.....415 Burns, Detroit
Waller, John P.....31640 Myrna, Livonia
Walser, Howard C.....459 Fisher Bldg., Detroit 2
Walt, Alexander J.....Detroit Receiving Hosp., Detroit 26
Walter, Arthur W.....14201 Rutland Rd., Detroit 27
Walter, Floyd J.....18714 Grand River Ave., Detroit 23
Wang, Chun Heng H.....25500 Edgemont, Southfield
Wang, Joy Ya Hsiang.....35550 Michigan, Wayne
Warner, Peter L. (L).....15320 Artesian Ave., Detroit 23
Warren, Bernice K.....18984 Livernois, Detroit 21
Warren, Irving A.....18984 Livernois, Detroit 21
Warren, Max W.....20001 Shrewsbury St., Detroit 21
Wass, Richard A.....3815 Pelham Rd., Dearborn
Wasserman, Harold.....19001 W. Seven Mile Rd., Detroit 19
Wasserman, Lewis C.....300 W. McNichols, Rd., Highland Park 3
Waszak, Chas. J.....2501 W. Grand Blvd., Detroit 8
Waters, William L.....19203 Grand River, Detroit 23
Watson, Harwood G.....935 S. Military Ave., Dearborn
Watson, James E., Jr.....18524 Grand River, Detroit 23
Watts, Fredk. B.....16321 Mack Ave., Detroit 24
Watts, John C.....7360 12th St., Detroit
Watts, Jos. C.....20905 Greenfield, Southfield
Wayne, Morris A.....15930 Livernois Ave., Detroit 38
Weaver, Clarence E. (R).....1260 S.E. Fourth Ct., Deerfield Beach, Fla.
Weaver, Delmar F.....1100 Bishop, Detroit 30
Weber, Karl W.....18101 E. Warren Ave., Detroit 24
Weber, Richard D.....2331 Van Alstyne, Wyandotte
Weber, Richard E.....18245 Livernois, Detroit 21
Webster, Jeremy D.....20045 Mack, Grosse Pointe
Webster, John E. (A).....47 Pine Court, Detroit 26
Weckstein, Marvin S.....28290 Tavistock Trail, Southfield
Weed, Milton R.....1059 Berkshire Rd., Grosse Pte. Pk. 30
Wehenkel, Albert M. (L).....7356 12th St., Detroit 6
Wehr, Maurice B.....2355 Fort St., Lincoln Park
Weidner, John H.....25701 Joy Road, Dearborn Heights
Weiksnar, John F.....1800 Tuxedo, Detroit 6
Weiner, Allen D.....21415 W. Eight Mile, Detroit 19
Weiner, Maurice B.....20211 Greenfield, Detroit 35
Weingarden, David (L).....13240 Vassar Dr., Detroit 35
Weinstein, Jacob.....4237 Grand River Ave., Detroit 8
Weintraub, G. S.....13735 W. 8 Mile Rd., Detroit
Weisberg, A. Allen.....20 W. Seven Mile Rd., Detroit 3
Weisberg, Harry.....15101 W. McNichols Rd., Detroit 35
Weisberg, Jacob.....15101 W. McNichols Rd., Detroit 35

Weisenthal, Irvin I.............5764 Woodward Ave., Detroit 2
Weiss, Casimir P.....................10036 Jos. Campau, Detroit 7
Weissman, Fredrick............20905 Greenfield Rd., Southfield
Welch, John H.................18550 W. Outer Dr., Dearborn 7
Weller, Charles N. (R).........................466 Gardner, Clawson
Wells, Herschel J.....................Wayne Co. Gen. Hosp., Eloise
Wells, Martha L. (A)................760 Fisher Bldg., Detroit 2
Welsh, Gary J. O....................................3919 John R., Detroit
Weltman, Carl G. (A)........................Rt. 2, Snead Island, Palmetto, Fla.
Wendt, Vernon E.............................1401 Rivard, Detroit 26
Wenokur, Milford E.........15845 New Hampshire, Southfield
Wenzel, Jacob F.....................18555 E. Warren, Detroit 36
Werle, Peter P.........62 Greenbriar Lane, Grosse Pte. Shores
Wertz, Wm. J..2033 Park, Detroit 26
West, Howard G.............................12739 Puritan, Detroit 27
West, Howard J...............................Harper Hospital, Detroit
West, Malcolm E..........................6309 Charlevoix, Detroit 7
Weston, Bernard....................20403 Snowden Ct., Detroit 35
Weston, Earl E.............18101 Jas. Couzens Hwy., Detroit 35
Weston, Horace L......................28 W. Adams St., Detroit 26
Weyher, Russell F..................5383 Oakman Blvd., Detroit 4
Whalen, Neil J.....................1553 Woodward Ave., Detroit 26
Whaley, Robert L..........................3150 2nd Ave., Detroit 1
Wharton, Thos. V.........................1809 Oak St., Wyandotte
Wheatley, Charles E..........................4407 Roemer, Dearborn
Wheeler, Stewart C.....18901 W. McNichols Rd., Detroit 19
Whelan, Jos. L.........................1360 Oxford Rd., Detroit 36
White, Daniel B.................408 David Whitney Bldg., Detroit
White, Donal L.............................Henry Ford Hosp., Detroit
White, Donald H.........................20685 Meridian, Grosse Ile.
White, Jacob E.............................3413 McDougall, Detroit 7
White, Milton W.....................1439 E. Outer Dr., Detroit 34
White, Prosper D...................58 W. Adams Ave., Detroit 26
White, Theodore M.....................7159 Michigan, Detroit 10
Whitehead, Leston S...........1553 Woodward Ave., Detroit 26
Whitehead, Walter K..........1553 Woodward Ave., Detroit 26
Whitehouse, Fred. W...........2799 W. Grand Blvd., Detroit 2
Whiteley, Robt. K.................608 Eastland Cen. Prof. Bldg., Detroit 36
Whitelock, Edward H.....................1809 Oak St., Wyandotte
Whitman, James E.........3001 E. Seven Mile Rd., Detroit 34
Whitney, Elmer L. (L)....2 Kenberton Rd., Pleasant Ridge
Whitrock, Robt. M.........20250 Mack Ave., Grosse Pointe 36
Whittaker, Alfred H. (L)................17000 E. Jefferson Ave., Grosse Pte. 30
Whitten, James I..........................21223 Harvard, Southfield
Wiechowski, Henry E.......10345 Joseph Campau, Detroit 12
Wiener, Israel..............13011 W. McNichols Rd., Detroit 35
Wiener, Morton J..........................150 Livernois, Ferndale 20
Wietersen, Fred. K.................18700 Meyers Rd., Detroit 35
Wikiera, Edward S.......................15120 Michigan, Dearborn
Wilcox, Leslie F. (A)..............................505 Middlesex Rd., Grosse Pt. Park
Wilhelm, Rudolf E.............751 S. Military Rd., Dearborn 7
Wilhelm, Seymour K..........13011 W. McNichols, Detroit 35
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Williamson, W. A.................2585 W. Grand Blvd., Detroit 8
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Willoughby, Wm. A.......................974 Fisher Bldg., Detroit 2
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Wilson, Gerald S.................3011 W. Grand Blvd., Detroit 2
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Wisniewski, E. M...................................950 E. Maple, Birmingham
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Wittenberg, Samson S.................18718 Woodward, Detroit 3
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Michigan State Medical Society
One Hundredth Annual Session
September 19-21, 1965

CALL TO ORDER AND SPECIAL REPORTS

1. Call to Order

The Annual Session of the Michigan State Medical Society House of Delegates, held at the Sheraton-Cadillac Hotel, Detroit, Michigan, on September 19-21, 1965 in conjunction with the 100th Annual Session of the Society, convened at 8:10 p.m., J. J. Lightbody, M.D., Speaker and L. F. Hayes, M.D., Vice Speaker, presiding.

2. Report of Credentials Committee

Chairman R. J. Huebner, M.D., reported: "Mr. Speaker, there are 86 members present, not more than 50 per cent from any one county."

3. Invocation

The Speaker called upon W. C. Beets, M.D., to give the invocation.

4. Speaker's Remarks—J. J. Lightbody, M.D.

It is a pleasure to welcome you to the 100th Annual Session of the House of Delegates. I also want to offer a special welcome to our many guests and members of the press, radio and television.

During the past year the House of Delegates has had seven committees which were authorized to study certain problems and to report back to the House at this Session. These committees are:

Centennial Advisory Committee.
Committee on Constitution and Bylaws.
Committee on Certificates of Commendation.
Committee to Choose Michigan's Foremost Family Physician.
Committee to Study Emergency Care in Hospitals.
Committee to Study Multi-County Medical Societies in the State of Michigan.
Committee to Study Procedures of the House of Delegates.

The reports of these Committees are available to the House and are incorporated in the Handbook. Because of the urgency of action on the reports of three of these Committees, namely, Certificates of Commendation and Michigan's Foremost Family Physician, and Procedures of the House of Delegates, I have asked these three to report directly to the House; the reports of the four remaining Committees of the House will be referred to the reference committees.

This year, as in the past, we have invited the deans of our two medical schools, Dean Hubbard of the University of Michigan and Dean Gardner of Wayne State University, to the meetings of the House of Delegates; and we have also invited Dr. Hunt, dean of the College of Human Medicine of Michigan State University.

Representatives of the junior and senior classes of our two medical schools have accepted invitations to attend our meetings, and they will be introduced individually at an appropriate time.

Every year there are some new Delegates attending the meetings of the House for the first time. I would like those Delegates and Alternates who are attending meetings for the first time to stand as their names are read.

Ray L. Hockstad, M.D., Delta-Schoolcraft
Ernest P. Griffin, Jr., M.D., Genesee
Dennis E. VanAlst, M.D., Wexford-Missaukee
James A. Read, M.D., Oakland
Irvin A. Wilner, M.D., Wayne
Ernest L. Stefani, M.D., Wayne
Donald T. Conley, M.D., Marquette-Alger
Richard J. McMurray, M.D., Genesee
John J. Vrbanac, M.D., Oceana

(The following report of the Speaker was presented to the Delegates in printed form.)

This is a brief review of the implementation of resolutions from the 1964 House of Delegates.

Resolution 1 authorized an annual recognition of Michigan's Outstanding Physician and requested that a committee be appointed to make the selection for this award from nominations submitted by component medical societies.

Such a committee has been appointed. It has met and made its selection and will report to the House of Delegates.

Resolution 2 declared MSMS support of voluntary area-wide hospital planning by a committee having adequate representation of practicing physicians, the hospital associations and the communities. This position of the Michigan State Medical Society was transmitted to the greater Detroit Area Hospital Council and the Michigan Hospital Association, as directed in the resolution.

Resolution 3 urged that medical staffs in hospitals be consulted by the hospital boards of trustees by the democratic nomination and election of all chiefs of staff and of services in hospitals. As instructed, this action was sent to the Boards of Trustees of all private non-governmental hospitals in Michigan.

Resolution 4 urged that The Council disseminate information regarding the advantages of medical practice in smaller towns in Michigan to the wives of senior medical students, residents and interns, through the Woman's Auxiliary to the Student American Medical Association and that this be done at the county as well as the state level. It was urged that formal liaison committees be formed between component medical societies and local SAMA chapters and between the auxiliaries of these two groups.

The Council requested the Michigan Health Council, because of its close liaison with the SAMA chapters, to incorporate this suggestion of the House of Delegates in its program of liaison with SAMA chapters and auxiliaries in Michigan.

The Michigan Health Council has activated a publicity campaign in Student AMA publications concerning the advantages of practice in rural areas and this subject has become a component part of the Health Council's liaison activities with SAMA groups. The possibility of displaying an exhibit on this subject at the SAMA national meeting is being seriously considered.

Resolution 5 requested the Finance Committee of The Council, which had been studying the question of remuneration to officers of MSMS, to enlarge its study to include Councilors, and Delegates to the AMA. After considerable study by the Finance Committee and The Council, the Council in its Annual Report made the following recommendation to the House: (1) That MSMS not remunerate AMA Delegates beyond expenses; (2) that MSMS not remunerate Councilors beyond expenses; and (3) that remuneration of component medical society officers be left to the discretion of the component medical societies.

Resolution 6 requested establishment of an MSMS Section on Orthopedic Surgery. The House took no action on the resolution, but referred it to the Standing Committee on Constitution and Bylaws which was "already authorized to study criteria for section membership and other details which should be spelled out before new sections are created."

Resolution 7 requested that the Legal Affairs Committee be directed to initiate bills to improve the Michigan Medical Aid to the Aged Act. Toward this end, the MSMS Committee on Aging, the Michigan Commission on Aging and the Michigan Health Council were to be asked for suggestions. Also, all component medical societies were to be encouraged to more fully implement the MAA Program in Michigan. The Council referred this resolution to the Legal Affairs Committee which requested and received suggestions for improvement in the Act from the above-mentioned groups, and a bill which incorporated these suggestions was introduced in the Michigan Legislature. The bill was not adopted during the 1965 Legislative Session but possibly may be adopted in the next Session. (For further details, see Annual Report of the Legal Affairs Committee.)

Copies of the resolution were sent to component medical societies for information.

Resolution 8 was disapproved by the House.

Resolution 9 recommended the establishment of a committee to assemble "pertinent information concerning careers in medicine and paramedical fields, for distribution to component medical societies, encouraging them to initiate an appropriate counseling program in these fields on a local level."

It was decided that rather than establishing a new committee to carry out this single program this resolution should be referred to an existing committee for implementation. It was subsequently referred to the Liaison Committee with Residents, Interns, and Students, which now has the project under consideration.

A substitute resolution for Resolutions 10 and 17 directed that a special committee composed of "equitable" representation of (1) private practitioners and (2) representatives of the public health services be directed to develop a program for coordinating public health services (those dealing with community health problems) and personal health services (those involving specific diagnosis and treatment of the individual). Such a committee has been appointed but has not yet submitted its report.

Resolution 11 approved the principle of a Judicial Board and authorized the establishment of a Judicial Commission appointed by the MSMS President, to study criteria of medical care and frequency of use, and to prepare recommendations providing for a permanent Judicial Board and system, to become effective immediately following the 1965 MSMS Annual Session.

The Judicial Commission was established, has met and prepared its recommendations which will be presented to the 1965 House of Delegates as instructed. (See Annual Report of Judicial Commission.)

Resolution 12 was not approved by the House.

Resolution 13 authorized the establishment of a Committee on Medical Aspects of Organized Athletics and requested component medical societies to urge their members to assist in the provision of medical services for "organized athletic programs." This Committee was appointed by Council Chairman Hiscock. Copies of the resolution were also sent to component societies of MSMS for implementation.

Resolution 14 changed the name of the MSMS Tuberculosis Control Committee to the MSMS Committee on Respiratory Diseases. This change has been effected and MSMS records have been appropriately amended.

Resolution 15 recommended that a proposed increase in AMA dues be not approved and that the AMA encourage and assist component medical societies in developing better communications with their members, their respective state societies, the American Medical Association and the public.

This resolution was referred to the Michigan Delegation to the AMA for information. At the November 1964 AMA meeting the problem of communications was discussed and the AMA House of Delegates took action to establish a teletype communications system between AMA and state medical associations.

Resolution 16 instructed The Council to continue its study of a plan of financial assistance to needy physicians and their dependents and to report such a plan to the 1965 meeting of the House of Delegates. After considerable study by the Finance Committee and The Council, the following recommendation on this subject was adopted by The Council and referred to the House for action: "(1) There is apparently no great number of physicians in Michigan who require aid, based on previous committee surveys; (2) However, some state fund should be instituted to meet the need that does exist, financed through an increase in dues; (3) Such a state fund should be administered on a matching basis with component medical societies."

Resolution 17 was considered with Resolution 10 and a substitute resolution was adopted. (See Substitute for Resolution 10 and 17 above.)

Resolution 18 was disapproved by the House.

Resolution 19 called for a federal subsidy program to aid in the purchase of health insurance for the aging, and was to be forwarded to the AMA "for action."

The Council submitted this resolution to the MSMS Delegation to AMA for implementation, and the Delegation introduced a resolution to this effect at the December 1964 Clinical Session of AMA. The AMA House of Delegates took no action on the Michigan resolution.

Resolution 20 was not acted upon by the House.

Resolution 21 endorsed in principle the adoption of merit rating by Michigan Medical Service. The sense of this resolution was transmitted to Michigan Medical Service for information.

Resolution 22 called for the appointment of a Committee on Evaluation of Prepaid Medical Services, by January 1, 1965, as a fact-finding group without punitive powers, to evaluate utilization of such services. The resolution instructed that sources of information submitted to the Committee was appointed by Council Chairman Hiscock and has been working on development of plans for committee procedures. (See Annual Report of Committee on Evaluation of Prepaid Medical Services.)

Resolution 23 supported the Michigan Diabetes Detection Program. For new developments and recommendations regarding the program, see the Annual Report of the MSMS Diabetes Control Committee.

Resolution 24 requested establishment of a Section on Allergy and Applied Immunology. The House took no action on the resolution, but referred it to the Standing Committee on Constitution and Bylaws which was "already authorized to study criteria for section membership and other details which should be spelled out before new sections are created."

Resolution 25 opposed a proposed Rule 311.2(2) of the General Court Rules of Michigan, which would waive the patient-physician privileges upon commencement of a personal injury suit, and instructed that the vigorous opposition of MSMS to this proposed rule be made known to the State Bar of Michigan. The Council referred this matter to the MSMS Liaison Committee with the State Bar. This Committee ascertained that a committee of the State Bar has recommended the proposed rule to the State Bar Commissioners. No action will be taken by the Commission until October or later. The MSMS Committee has formally transmitted MSMS and House of Delegates objection to the proposed Rule 311.2(2). (See Annual Report of Liaison Committee with State Bar of Michigan.)

Resolution 26 urged that every Michigan doctor of medicine become a member of the Michigan Doctors Political Action Committee and AMPAC. This resolution was transmitted to component medical societies for information.

Resolution 27 was not acted upon by the House.

Resolution 28 expressed appreciation to John M. Sheldon, M.D., for his outstanding service to MSMS as Chairman of the Postgraduate Medical Education Committee. A copy of the resolution was forwarded to Doctor Sheldon as instructed by the House.

Resolution 29 called for an official MSMS recommendation that the State Mental Health Department be a separate principal department of state government and, if necessary, vested with certain mental health responsibilities now assigned to other agencies. This resolution was referred to The Council "without prejudice" for any appropriate action.

The Council referred the resolution to the Legal Affairs Committee, requesting that it be considered with a representative of the Mental Health Committee. The Legal Affairs Committee approved this position and it was subsequently transmitted to Governor Romney for his information.

Resolution 30 recommended that a place on driver's licenses be provided for recording the status of tetanus immunizations. It also recommended that the Commissioner of Health be requested to prepare a memorandum to be sent with each driver's license issued, which would explain and remind each licensee of the importance and technique of tetanus immunization.

MSMS has purchased 1,000,000 stickers which provide space for tetanus immunization information and which can be attached to the laminated plastic driver's licenses now provided. These are being sent to Michigan physicians for distribution to their patients.

It has proved to be impractical to insert a memo with each license issued; therefore, it has been suggested to the State Health Department that it prepare this public health information in placard form (with a brochure if desired). The Secretary of State has agreed to handle placard distribution to license examiner points.

Resolution 31 directed that an appropriate committee of MSMS establish standards and procedures for classification and licensure of medical facilities for the care of subacute illnesses.

The Council referred this matter to the MSMS Hospital Relations Committee. Tentative criteria for the classification of "subacute facilities"—i.e., nursing homes—were recommended by the Hospital Relations Committee and approved in principle by The Council at its June 16, 1965 meeting. (See Annual Report of Hospital Relations Committee.)

Resolution 32 directed The Council to investigate and document allegations that some insurance agencies will not renew malpractice insurance coverage unless the physician takes a "package deal" and, when appropriate, bring the matter to the attention of the Michigan State Insurance Commissioner.

The Council referred this resolution to the Finance Committee for implementation. A questionnaire was developed and mailed to all MSMS members to ascertain the extent of this problem. (See report of survey results and their interpretation in Part III of the Annual Report of The Council.)

Resolution 33 was not acted upon by the House.

Resolution 34 instructed that the State Board of Registration in Medicine be requested to inform The Council (1) whether it has adequate enforcement power under the present Medical Practice Act and, if not, in what respect it should be strengthened, (2) whether it has an adequate budget to administer an effective program of enforcement and, if not, what additional funds are required and the purposes for which they will be used.

This resolution was transmitted to the State Board of Registration in Medicine and MSMS was informed by Board Secretary Swanson that it had been filed as an amendment to the original budget of the State Board.

The matter of the power of enforcement of the Board of Registration in Medicine is being explored with the Michigan Attorney General, with an opinion being sought regarding the extent of the responsibility of the Board in dealing with unprofessional conduct and "moral turpitude" under the present terms of the Michigan Medical Practice Act.

Resolution 35 stated the position that when any new medical school is to be established or a basic and fundamental change is to be made in an existing school, the advice and cooperation of state and county components of the AMA should be sought in the establishment of medical educational policies. Copies were sent as instructed to all members of the boards of control at Wayne State University and the University of Michigan.

Resolution 36 was not acted upon by the House.

Resolution 37 was not acted upon by the House.

Resolution 38 directed that the monetary unit value and relative values for each section (that is, surgery, medicine, radiology, pathology) of the Michigan Relative Value Study be considered separately and independently. Accordingly, the Relative Value Study Committee completed its task of studying the matter of alleged inequities in the Michigan RVS and submitted its report to The Council in July. (See Annual Report of Relative Value Study Committee.)

Resolution 39 directed that an appropriate committee investigate immediately the problem of malpractice insurance in Michigan, to include (1) availability of insurance from commercial carriers; (2) premium rates; (3) frequency of malpractice and suits, and (4) feasibility and desirability of establishment of a malpractice insurance company by MSMS. The resolution also directed that the Michigan Delegation to the AMA be requested to initiate a similar study of malpractice insurance.

The resolution was referred to the Professional Insurance Plans Committee. Questions regarding the availability of malpractice insurance, premium rates, etc., were incorporated in the survey mentioned in connection with Resolution 32 above. This information and the advisability of MSMS setting up its own insurance company are discussed in the Annual Report of the Committee on Professional Insurance Plans.

The Michigan Delegates to AMA introduced a resolution at the December 1964 Clinical Session of AMA to initiate a similar AMA study, but the resolution was not adopted because "it was felt that these medical-legal problems can be best handled on the state level, utilizing to the fullest extent possible the wealth of information available from AMA."

Resolution 40 was not acted upon by the House.

Resolution 41, expressing sympathy to the family of AMA President Norman A. Welch, M.D., who died September 3, 1964, was forwarded to Mrs. Welch and to the Board of Trustees of the American Medical Association.

Resolution 42 instructed that component medical societies be urged to initiate or review active loan and scholarship programs for medical students residing in or coming from these respective counties.

This resolution was transmitted to component medical societies for implementation.

Resolution 43 supported the MSU School of Human Medicine. This resolution was transmitted by letter to the Executive Office at Michigan State University and to appropriate committees of the Michigan Legislature.

THE REFERENCE COMMITTEE on Reports of Officers, John W. Moses, M.D., Chairman, acknowledged the excellent job Speaker Lightbody has done and complimented him on his accomplishments. The committee also made the following comments on the Speaker's review of implementation of resolutions from the 1964 House of Delegates:

Resolution 4. Strongly recommended a rural practice exhibit at the national student AMA meeting.

Resolution 16. Expressed belief that the AMA would be in a better position to implement a plan of financial assistance to needy physicians and their dependents.

Resolution 26. Recommended further action to induce more physician participation in MDPAC.

THE HOUSE adopted the report of the Reference Committee.

5. President's Address—O. B. McGillicuddy, M.D.

Mr. Speaker, Members of the House of Delegates and Guests:

It is my pleasant duty to report to you on my year as your President. After a good many years of exposure to the inner workings of the Michigan State Medical Society it came as somewhat of a surprise to me that the Presidency of the Society was not the sort of honorary vacation that I had envisioned. As Chairman of The Council for two years I used to wonder what the President was doing. Now I know.

He was invited and expected to attend almost every meeting remotely connected with medical matters. The prestige of his office was a passport to the head table, where his absence was obvious regardless of what excuse he used to escape.

He was at the mercy of toastmasters who loved the sound of their own voice and who didn't give up the microphone to the President until the audience was completely exhausted and sober.

He was expected to speak on medical political problems and yet, if he was candid and frank, his audience of busy physicians could hardly hide their resentment at his criticism of their political inaction.

He was the target of occasional snide remarks by laymen gloating over Medicare's success and the humiliation of a proud profession. Similar remarks from critical doctors were more difficult to bear even when spoken in jest.

But enough of the President's problem. The rewards of this office are far greater than the tribulations. The splendid contributions of many of the members have been inspiring and gratifying.

The response to our plea for help in contacting State legislators during the recent rash of dangerous health bills was splendid and for the most part successful. However, even some of our friends in the Legislature stated they were antagonized on occasion by the patronizing, superior attitude of some of the testifying doctors. I plead guilty to this charge. When I appeared before a Senate committee on the chiropractic bill my effectiveness was obvious when the committee approved the bill 15 minutes after I left the committee room.

The battle for good health legislation is not over. This fall may well be even more crucial than the spring session. We will need the help of every member to combat the political advantage of those who would legislate for themselves diagnostic and therapeutic modalities for which they are not qualified. It is no secret that these cults and groups, who aspire to the privileges and responsibilities of medical doctors, have been generous with their funds in the campaigns of newly elected legislators.

The committee structure of your State Society has never functioned better than during the past year. Witness this Centennial meeting and imagine the amount of committee and staff work involved in its planning. It is without doubt the most ambitious State medical meeting ever conceived. I cannot leave this subject without paying high honor to our loyal and diligent staff; they have worked far beyond the call of duty. [Applause]

It is not practical at this time to mention with pride all of the fine committee activities, but I must boast of my appointees to the Judicial Study Commission. This group of distinguished, conscientious, medical leaders, with the invaluable counsel of Mr. Lester Dodd, came from all over the state to the Headquarters for long afternoons of deliberation. The ultimate evaluation of their decisions rests with you, and I am confident you will treat their suggestions thoughtfully and will adopt what you honestly feel is best for the practice of medicine in Michigan.

Organized medicine in Michigan has known 100 years of progress—100 years of devoted service to the people and the doctors of this State. During this period there has been no lack of perplexing problems, but the coming year portends a period of adjustment that will task all of us.

Medicare is the law of the land and cannot be wished away. If we are to have any part in its functioning we must insist on our right as the purveyor of services to direct its medical aspects. This much has been assured us by the bureaucrats; but it will require more organized effort on our part than we have ever expended before. And unless we are adjectly willing to see Medicare extended to all ages, it will behoove us to actively engage in electing legislators who are dedicated to preserving some of the competitive practices that have made our medicine the finest in the world.

Now I thank you sincerely for the honor and privilege of serving as your President, and implore you to give my successor all of your cooperation and help.

Thank you.

THE REFERENCE COMMITTEE on Reports of Officers, John W. Moses, M.D., Chairman, expressed appreciation for the long hours and inconvenience the President experienced in behalf of the MSMS and its members and congratulated him for a job well done.

THE HOUSE adopted the report of the Reference Committee.

6. President-Elect's Address—Luther R. Leader, M.D.

A year ago you Delegates here in Detroit selected me as your President-elect. During the past year I have attended MSMS Council meetings, served on several important committees, and represented you at several functions in Michigan and outside the State.

This has been a busy year with the usual Society activities, a very busy legislative year, and all the planning for the Centennial Session. This coming year may be even busier.

This coming year will be very important to every physician in Michigan. Many of the Centennial activities will be continued. Postgraduate education opportunities are great. The Legislature has many health bills to consider. And the advent of Medicare certainly will demand our attention.

In regard to Medicare, we have contended that it would be unwise to use coercive power and take tax funds from many who are in need and to provide medical care to many who are not in need. We feel that such a program, if enacted, should be operated at the State level.

Medicare was passed. We can take some consolation, however, in the fact that it was voted in by the smallest margin on a test vote of any of the Administration's "must" legislation. We believe the Congress and the Administration passed a bad bill. Yes, President Johnson did win—and we sincerely hope the public has not lost.

Never before has the individual physician been more needed in his medical organization—and never has he needed it more than he does today.

The medical organization certainly must continue to meet the challenges of postgraduate education, public service, career recruitment, and so on; but MSMS must be active on legislative matters.

We are ready, willing and able to provide advice and guidance as the Federal Government seeks to implement Medicare in Michigan. Our committees have met with the Governor and with leading legislators to make sure the implementing regulations are fair and just to every patient.

But it is not enough to confer with the Governor and with legislative leaders. It is vital that our advice be heard in drafting the rules and regulations of the departments of government which will more and more be administering medical services. I urge that adequate attention be given to this problem by our committees, and that sufficient staff be employed to provide for liaison with governmental agencies and personnel.

We want the program to be developed with a minimum of confusion, with the stated benefits provided in the most logical way, and with as few disturbances as possible to the practice of good medicine.

Medicine is practiced well in Michigan. For a century now the physicians, their county and state associations, their specialty organizations, their medical schools and the State have worked well together to constantly improve the quality of medicine and the atmosphere for the pursuance of excellence.

One hundred years ago the physicians who met here made a monumental decision to organize the Michigan State Medical Society.

Today you men must act on many far-reaching questions. One of these, I believe, is the report of the Judicial Commission. Personally, I will urge you to adopt the report and to work for further improvements in this vital aspect of medical practice.

It may be that some will find fault with various specific provisions of the plan proposed by the Judicial Study Commission. I sincerely hope, however, that the magnificent concept embodied in this report will not be sacrificed or weakened because of differences of opinion with respect to the mechanics of implementing it.

I am convinced that such a judicial system, administered by high-minded men elected directly by their peers and separated from the legislative and administrative functions of the Society, will, when adopted and given opportunity to function, become a landmark in the custom of the Society.

I believe that such a system will not only make for a better Medical Society by maintaining and strengthening ethical standards of practice, but will help to improve the public image of the medical profession, and will be a long step forward toward ultimate legal self-licensing and self-discipline.

Another major question before this House of Delegates deals with the relationship between the Michigan State Medical Society and the doctors of medicine and doctors of osteopathy. You have a committee report to consider, and likely several resolutions in this area. The Legislature and many influential citizens will be waiting for your decisions on this matter. Joe Citizen, who is concerned about quality medicine, is interested in this issue too because he does not want any duplication of state and federal funds for a Michigan college of osteopathy when more medical students could be trained at present universities for far less money.

We have invited quite a number of doctors of osteopathy, as recommended by the county medical societies, to join us at our Centennial for our postgraduate medical programs. When historians look back at MSMS fifty or 100 years from now the 1965 Session may stand out because osteopaths attended for the first time.

All of us physicians treat all our patients alike, regardless of race, color or creed. It has always been that way. We also treat the growing number of foreign and colored physicians in our State with the same regard. It is a pleasing note that more and more of these skilled men are being accepted on hospital staffs, are attending continuing medical education courses, and are participating actively in our county and state societies.

We are remiss when we permit some to make slurs about the medical men and women from other nations and from other races or to question our concern for their welfare in this country.

Many of these foreign-trained physicians are choosing to become citizens and residents of Michigan. We welcome them. We need them as we constantly seek to obtain more physicians for our Michigan residents.

MSMS and the county societies are active in many ways to recruit new physicians. The Michigan Health Council Professional Placement Service aids both communities seeking physicians and those physicians interested in practice here.

Individually, each of us can do more. Our ongoing interest must spread over many years. We must be alert to spot potential physicians and then encourage them while they are in training. We must work closer with the universities when these young people serve their internships in our Michigan hospitals. We can develop new patterns too with the residents as they improve their skills in our institutions.

Your specific suggestions for State and county committees will be appreciated. May I hear from you.

One of the exciting developments of the Centennial has been the Healthmobile. I urge each of you to look at the Healthmobile this week in Hall C at Cobo Hall. It is the sincere wish of The Council and the officers that the Healthmobile will be able to visit each county medical society territory. We have asked the counties to tell us what week they would like to have it, and where. It will be designed to tell the public about the advances in medicine, and it will do much to help recruit young people for medical careers.

The Healthmobile will be the major way in which the Michigan State Medical Society will continue the year-long observance of our Centennial.

In closing, next year will present many opportunities and challenges, and I pledge to serve you to the best of my ability.

THE REFERENCE COMMITTEE on Reports of Officers, John W. Moses, M.D., Chairman, recommended approval of the remarks of the President-Elect.

THE HOUSE adopted the report of the Reference Committee.

7. Report of Woman's Auxiliary to Michigan State Medical Society—Mrs. Milton R. Weed, President.

In this Centennial Year of the Michigan State Medical Society, its 39-year-old Woman's Auxiliary set new records in membership, health career programs, support of education, legislative activity and community projects.

Membership reached a record total of 3,423.

Notable success was achieved in recruiting members-at-large. Dynamic Chairman Mrs. Robert K. Hart, armed with a resolution passed by the 1964 Michigan State Medical Society House of Delegates recommending that a "plea be made to component medical societies to encourage membership of spouses in the Woman's Auxiliary," wrote the Executive Secretaries of the 13 County Medical Societies having no organized auxiliary asking for the names and addresses of married society members. She then sent a personal letter and complimentary copy of the *Bulletin* to each doctor's wife. Result—a 150% increase in this membership category.

Organized Auxiliary membership in Michigan is still only half its potential. But in May 1965, the Council of the Wayne County Medical Society—largest County Society in the State with a membership of 3,000 physicians—endorsed the concept of team membership. Joint billing was approved and goes into effect January 1, 1966.

Health Career projects involved both education and scholarship support. County auxiliaries have established and continue to support 119 active health career clubs; 30 career days were sponsored. Jackson County's Health Careers Committee prepared a bulletin containing complete information on 15 medical and paramedical careers. This was distributed along with 15 posters, one for each career researched, to 20 schools and 2 colleges. Each committee member is expected to maintain personal contact with interested students from the 9th grade to training in their field of interest.

The State Auxiliary, for the 23rd year, continued its support of Michigan's TB Speaking Contest. About 3,000 students, representing 75 schools in 34 counties participated. Regional winners were brought to the State Capitol at Lansing and the final competition was broadcast live on radio.

Health careers were tangibly supported by various scholarships amounting to $7,355, and by loan funds totalling $6,687.60.

In addition, contributions to AMA-ERF of $18,200, set a record high, exceeding last year's return by $2,000.

The Auxiliary continued to maintain close relations with Michigan's five WA-SAMA groups: one at each of the Medical Schools and three in local hospitals. One of the State Board members is liaison officer to WA-SAMA. WA-SAMA representatives report on their activities at the Mid-Year meeting and Annual Convention; and the State Auxiliary contributes $200 to help defray WA-SAMA representatives' expenses to their national convention.

The International Health Activities Committee set records in two general areas.

Michigan-conceived International Hospitality continued to be a priority project. More than 100 foreign physicians and their families from 21 countries were entertained in members' homes.

International aid to foreign physicians was provided through Detroit-based World Medical Relief and other agencies. World Medical Relief received about two carloads of drug samples, instruments, crutches, medical and surgical supplies and two iron lungs. In addition, financial assistance was provided toward the purchase of a new warehouse. Other agencies throughout the world received about three tons of drugs, supplies, textbooks and journals.

Several counties maintain group memberships in Project *Hope*.

Legislative activity was accelerated. Legislative Chairman, Mrs. Norbert T. Pasternacki, a member of the Michigan Bar Association, tirelessly attended county meetings throughout the State, interpreting pending bills at both the State and National level.

Wives of State Legislators were entertained at the Annual Legislative Brunch sponsored by the auxiliary members of Ingham County. This is a highly effective public relations project.

The Precinct Action Course was undertaken by three counties. Several counties provided absentee ballots to hospitalized patients.

In Community Service auxiliary members ran the gamut. Two projects received wide publicity.

Macomb County sponsored a baby sitter training course consisting of three sessions—one each on Child Care, First Aid, and Fire Safety. These were given in four high schools simultaneously with the cooperation of the local school boards, fire and police departments, Public Health Department, Safety Council, Bell Telephone Company and several insurance companies. Certificates of completion of the course were awarded to 200 students. This project received widespread favorable publicity through all channels of communication.

Wayne County presented a panel on safety at a tea for representatives of women's organizations throughout metropolitan Detroit featuring a 15-minute talk by a judge of Traffic Court.

County Auxiliaries assisted their local medical societies in many ways—professionally and socially. The State Auxiliary supplied, from its members, 13 secretaries for 13 individual discussion groups at the Congress on Mental Illness and Health held in Detroit. Auxiliary representatives participated actively in some of the planning sessions for the celebration of the Centennial of the Michigan State Medical Society in September.

The Auxilium, publication of the WA-MSMS, published three times a year, continued to provide information on the highlights of the Auxiliary year to members throughout the State. More frequent issues might be beneficial. At the request of the editor of *Michigan Medicine,* the president of the Auxiliary contributed a guest editorial on Auxiliary activities to the March issue.

Overall, this has been a good year for the Woman's Auxiliary. The Auxiliary is grateful for the courteous assistance, helpful counsel and consistent support provided by the Michigan State Medical Society staff both in Lansing and Detroit.

THE REFERENCE COMMITTEE on Reports of Officers, John W. Moses, M.D., Chairman, reported "we commend the excellent results of the recruitment program, and hope the next year will be equally rewarding. We especially commend the Health Career projects and International Health Activities. We note with interest the excellent work done in community service, especially the baby-sitter training course, and hope there can be more effort in this endeavor."

The Committee recommended that more physicians urge their wives to become active in the Auxiliary and expressed sincere congratulations to Mrs. Weed for a fine job.

THE HOUSE adopted the report of the Reference Committee.

8. Report of the Michigan State Medical Assistants Society—Miss Phyllis Marquardt, President

Activities

The Eighth Annual Convention of the American Association of Medical Assistants was held in Oklahoma City, Oklahoma, in October, 1964. Michigan was represented by four delegates and two alternates. Seventeen additional Michigan members attended as well as Dr. Glenn E. Millard, Chairman of MSMAS Advisory Committee and member of AAMA Advisory Board, Mrs. Millard and Miss Helen Schick, Educational Coordinator of Michigan Medical Service and Honorary member of MSMAS. All of the Michigan members were identified by the white sharkskin shifts they wore.

In November, the annual workshop was held for County Officers and Committee Chairmen, in Saginaw, with an attendance of 90. Present at this meeting was Glenn E. Millard, M.D., Chairman, MSMAS Advisory Committee.

The Michigan State Medical Society's Officers Conference, held in Grand Rapids, was attended by three representatives. The President briefly addressed this conference.

Three representatives attended the Sixth Annual Congress of the Professions, in Grand Rapids.

The President represented MSMAS at the Women's Division of the Michigan Safety Conference at the Lansing Civic Center.

Two representatives were present at the Michigan State Medical Society Emergency Conference on State Health Legislation, April 24, 1965, in Lansing.

The Eighth Annual Educational Seminar was held in Ann Arbor, April 25, 1965, with an attendance of 173. Lectures included the L. Fernald Foster lecture by Reed O. Dingman, M.D., Plastic Surgeon, University of Michigan, who spoke on "Modern Concepts of Plastic Surgery," F. Bruce Fralick, M.D., Ophthalmological Department of the University of Michigan, who discussed "The Eye in Systemic Disease" and "Operation Teamwork: The Medical Assistants' Role in Dental Health Education" by Kenneth K. Shook, D.D.S., Chairman of the Committee on Dental Health Education of the Michigan State Dental Association.

The first Leadership Training Seminar, in Michigan, sponsored by the American Association of Medical Assistants, was held in Port Huron on June 13, 1965, with 53 in attendance. AAMA Councilor was Miss Alice Budny, Milwaukee, Wisconsin and a past president of AAMA.

For the first time in Michigan the Certification Exmination was offered to the medical assistants at Highland Park Junior College, June 25 nd 26. There are now two Certified Medical Assistants in Michigan and ten members took the examination this June.

Fifty-four members, non-members and guests, including T. J. Trapasso, M.D., Advisor, attended the second consecutive Upper Peninsula Seminar in Marquette on July 27 and 28, 1965.

The president and president-elect attended the annual meeting of the Indiana Medical Assistants Association in Elkhart, Indiana, and the president attended the annual meeting of the Wisconsin State Medical Assistants Society, in Milwaukee, Wisconsin, where she addressed their first House of Delegates.

The Sixteenth Annual Convention will be held this week at the Statler-Hilton Hotel, Detroit, and the Michigan State Medical Assistants Society will open with the second session of the House of Delegates. There will be 93 delegates representing 23 counties. Under the heading of a scientific session a workshop type of meeting is being held, offering the members an opportunity to voice their everyday bothersome problems. Experts in the fields of insurance, public relations, professional management, medicine and education will form a panel to answer and discuss these "problems." We are foregoing our annual banquet in order to celebrate your 100th birthday with you.

We will again honor a medical assistant of the year.

"Operation Telephone Contact" was termed successful when the MSMAS members contacted MSMS members to remind them of the Centennial.

Membership

Total membership as of June 30, 1965: 882.

Bulletin

Four issues of the Bulletin were sent to our membership, AAMA Officers, Trustees, Advisors and State Presidents.

House of Delegates

Included in the delegates' packets this year are reports of all officers, committee chairmen, annual reports of the county presidents, agenda and convention rules. These packets were mailed to the 93 delegates prior to the convention.

Education

The in-service training programs continue in several areas. The AAMA Education Committee has been contacted regarding revision of the syllabi so that it would be geared more closely to the certification program.

Contact has been made with Ferris State College to serve as a testing center for the certification examination in the future. We will continue to utilize Highland Park Junior College.

Wayne State University has indicated an interest in the medical assistants program.

Legislation

We actively participated in the fight to preserve the practice of medicine from government encroachment. We have continued to work closely with the Legislative Committee of the Michigan State Medical Society regarding bills on Optometry, Chiropractic, Osteopathic College Authority and Podiatrists.

Conclusion

Following the annual meeting in September the various activities of our Society got underway. Re-activation of an old committee on Resolutions was established. New committees formed were Membership Extension and Insurance.

Closer liaison between the Michigan State Medical Society and the Michigan State Medical Assistants Society has been accomplished with the appointment of Mrs. Marjorie Karker, who has worked very closely with our Society.

We appreciate the fact that every issue of *Michigan Medicine* contained an item pertaining to our activities.

We shall make every endeavor to show our appreciation for the privilege of being associated with the Michigan State Medical Society, and assure you of our continued cooperation. We shall continue to make every effort to provide the best educational opportunities for all medical assistants, to promote public relations and assist you in the common interest of our patients.

We thank you for the use of the facilities for our board meetings and we especially thank Doctors Millard, Green, Trapasso, Johnson and Engelke for their counsel and continued guidance.

The Michigan State Medical Assistants Society wishes to congratulate you on the attainment of your 100th anniversary. May the friendly cooperation between our Societies continue for another 100 years.

We welcome you to attend any or all of our meetings at the Statler-Hilton Hotel on Wednesday and Thursday of this week.

THE REFERENCE COMMITTEE on Reports of Officers, John W. Moses, M.D., Chairman, commended the MSMAS for its excellent work and hoped the workshops and seminars would continue. It suggested that the group explore participation in local school Career Days. Commending Miss Marquardt for her leadership, the Committee recommended approval of the report.

THE HOUSE adopted the report of the Reference Committee.

9. Report of Michigan Delegates to the American Medical Association—Wm. A. Hyland, M.D., Chairman

The largest number of physicians and medically connected personnel in the 114-year history of the American Medical Association attended the sessions in New York City on June 20-24, 1965. Over 24,000 physicians were registered. Added to this were their families and other medically-connected people, making a grand total of around 65,000.

There were nearly eighty resolutions presented on various socio-economic, scientific and educational subjects.

Michigan presented five resolutions. Resolution 51: Subject—Commendation of the American Medical Association program for the public, and request for continued information through various media of scientific and socio-economic progress in medicine. Five other states presented similar resolutions.

With the rise in the polls against the adoption of Medicare by the public since being informed by the American Medical Association from February 1965 by television, news media, ads and radio discussion, the public for the first time has seemingly doubted the advantage of Medicare over other forms of health assistance to the needy by the government.

It was the opinion of our delegation and those of five other states that the American Medical Association should continue this manner of reaching the public and even to expand it.

The reference committee commended all five resolutions on this subject and compiled them in a substitute resolution which was passed by the House.

"**RESOLVED:** That the House of Delegates commend the Officers, Board of Trustees of the American Medical Association, its Task Force and the staff for their efficient and energetic conduct of a difficult campaign under highly unfavorable political circumstances; and be it further

"**RESOLVED:** That the American Medical Association leadership continue to advise and inform the public of the benefits of maintaining high standards of medical care through plans and programs." Passed unanimously.

"That the American Medical Association make every effort to continue and, where necessary, to expand its communication activities so that all physicians as members of component medical societies will be promptly, continuously and completely informed of developments in this critical area during the coming months."

In considering seven resolutions involving the report and recommendations of the President's Commission on Heart Disease, Cancer and Stroke, the House adopted a substitute statement which resolved:

"That the American Medical Association point with pride to the immense strides made in the approaches to the conquest of heart disease, cancer and stroke, under existing patterns of research and medical practice; strongly favoring the use of available financial support for extension of these patterns rather than replacement by a complex of medical control centers and satellites.

"That the American Medical Association oppose those particular Commission recommendations which call for and have stimulated proposals for hastily contrived and unproven sweeping changes in the pattern of medical research, education and patient care.

"That component state medical associations be urged to conduct conferences with medical educators and scientists, medical staffs of hospitals, medical society representatives, and other interested parties, for the purpose of exchanging information and for the development of such recommendations as may be appropriate for the continued improvement of medical education, research and patient care.

"That state medical associations be urged to report findings and recommendations resulting from these conferences to the AMA Board of Trustees, for the information of the Board, its councils, and the Association members."

The Gundersen Committee report, reviewing the size, makeup and functions of the House of Delegates, was postponed until the 1965 Clinical Convention in Philadelphia because certain parts of the Committee's work were not completed. Also, some portions ready were to be changed after discussions at this time.

The House adopted a reference committee report saying:

"It was apparent that if the organization of the House of Delegates of the American Medical Association, which is of paramount importance to the efficient and productive operation of the Association, is to be thoroughly studied by the Delegates, more time will be required."

The Gundersen Committee was appointed an ad hoc unit at the directive of the American Medical Association House in June 1963. The Committee, chaired by Gunnar Gundersen, M.D., of La Crosse, Wisconsin, a Past President of the American Medical Association, gave an extensive report.

The Council on Postgraduate Programs stated that the establishment of a new Section is an important change in the AMA structure, and offered a procedure for defining the qualifications for a new Section as well as the scientific programs of all Sections.

The procedure provides that (1) the group requesting formation of a new Section submit to the Executive Vice President a written request for approval; (2) the request be transmitted by the Board to the Council on Postgraduate Programs for evaluation of the petition; (3) if approved by the Council, a mandatory trial period of two years presently in effect be provided under the auspices of the Council; and (4) after such trial period, a recommendation for acceptance or denial of the petition for the establishment of a Section be made to the Board.

The House agreed, with certain word changes, and suggested that it be sent first to the Gundersen Committee and then to the appropriate AMA Council for consideration.

Beside the resolutions, the House considered reports from the councils, committees, Board of Trustees and the officers, as well as the Executive Vice President, and introduced the the President of the Woman's Auxiliary and the Student American Medical Association.

The House—

Directed the Board to review the subject of Federal assistance for operating expenses for health or medical education facilities.

Referred to the Board for consideration and appropriate action a ten-point legislative program outlined by the Minnesota delegation.

Instructed the Council on Medical Services and its Committee on Federal Medical Services to "remain alert to any deviations from policies of the Veterans Administration concerning the provision of drugs to veterans treated by private physicians, and to meet with pharmacy representatives so that the basic principles of freedom of choice of pharmacists be maintained."

Urged the Council on Medical Education to establish a standard date of appointment for all approved residency training programs.

Urged medical schools and agencies concerned with continuing education to incorporate "appropriate learning experiences" for physicians in counseling relating to sexual attitudes and behavior.

Adopted a resolution calling for continued efforts to secure the passage of legislation "which will remove tax discrimination against professional people," specifically HR 10 (Keogh) and HR 697 (Weltner), but turned down recommendations that the American Medical Association encourage its members to proceed at the state and county levels with the formation of corporations for the purpose of implementing an "organized effort in the courts to remove tax discrimination."

Accepted a Board of Trustees report stating that it had referred to the joint American Medical Association—American Bar Association Committee a previously introduced resolution designed to present a grievance against the alleged abuse of legal processes, named in the resolution as "vexatious litigation."

Referred to the Board of Trustees a resolution calling for the AMA to caution the public against discontinuing voluntary health insurance policies and prepayment plans for persons over 65 in "anticipation of pending legislation."

Directed the Board to study the opportunities and problems associated with Operation Head Start and other programs now operating or planned under the Economic Opportunity Act.

Amended the Bylaws to provide that the Vice President shall succeed to the Presidency should the President die, resign or be removed from office.

Disapproved a resolution by North Carolina requesting a "Permanent Advisory Committee on Study Policy and Planning." The Reference Committee felt this had merit but that, as the House was in session twice a year with the Board meeting six to eight times, they were in closer touch and had power to act for the House, whereas a study committee sort of "looking over their shoulder" could confuse matters. However, it did recommend that the Board keep in close touch with members of the AMA by frequent announcements as to decisions and future policy.

Agreed that hospital medical staffs and state and component medical societies be urged to encourage the establishment, maintenance, and proper use of cancer registries in hospitals, but that the establishment of such registries should not be made a requirement for accreditation by the Joint Commission on Accreditation of Hospitals.

Disapproved a series of resolutions urging the approval of an American Board of Family Practice, since such action would be in violation of established procedure for the creation of new specialty boards.

Reaffirmed AMA policy that human blood, as living tissue, should not be purchased under insurance contracts. It was recognized that exceptions may be necessary when there is need for unusually large numbers of transfusions, or whenever volunteer blood donors are not available.

Urged state and local medical societies to encourage the development of the Explorer Scout Program for Medical Specialty Posts, and noted that about 150 of the 21,000 Explorer Scout posts in the country are directly related to health.

Dr. Appel, expressing his personal opinion in his inaugural address at the Sunday session, said that if the omnibus Medicare bill is passed by Congress, the medical profession must do all it can to develop the good points and eliminate the bad points of the law. He declared that, regardless of personal opinion, "We do not have the right, either as physicians or citizens, to violate the law nor to violate the spirit of the law or its intent."

Outgoing President Donovan Ward pointed out: "If it were true that the public climate was the dominant factor affecting the decisions of those who make legislative history, we now would be winning both in the House and the Senate."

Dr. Charles Hudson of Cleveland, Ohio, was selected as President-elect. Dr. Hudson's unexpired term (to 1967) on the American Medical Association Board of Trustees will be filled by Dr. Irvin E. Hendryson of Denver, Colorado.

Re-elected to the Board for three-year terms were: Drs. Lester Bibler, Indianapolis; J. B. Copeland, Austin, Texas; Gerald D. Dorman, New York; and L. O. Simensgad, Osceola, Wisconsin.

Dr. W. Andrew Bunten, Cheyenne, Wyoming, was elected to a one-year term as the Association's Vice President.

Dr. Milford O. Rouse, Dallas, Texas, was reelected Speaker of the House of Delegates; Dr. Walter C. Bornemeier of Chicago was re-elected Vice Speaker.

Elected to the Council on Medical Education were Dr. Bland Cannon of Memphis, Tennessee; Dr. William Willard of Lexington, Kentucky (to succeed himself), and Dr. Earle M. Chapman of Boston, Massachusetts.

Named to the Council on Medical Service were Dr. S. Hoffman of Huntington, West Virginia, and Dr. Russell Roth of Erie, Pennsylvania, who was re-elected unanimously. Dr. George D. Johnson of Spartanburg, South Carolina, member of the Council on Constitution and Bylaws, also was re-elected unanimously.

In speaking about the Healthmobile referred to by Dr. Leader, it is over at Cobo Hall. The American Medical Association contributed handsomely to this, and I hope you will all have a chance to see it.

I wish to thank all the members of the House for allowing us, your Delegates, to serve you.

THE REFERENCE COMMITTEE on Reports of Officers, John W. Moses, M.D., Chairman, commended the Delegates for their fine efforts in support of important resolutions and congratulated Chairman Hyland and the Delegation for a very arduous task well done.

THE HOUSE adopted the report of the Reference Committee.

10. Report of Michigan Medical Service—Sidney Adler, M.D., President

(Mimeographed copies of the Summary of the MMS Annual Report and Supplementary Report were distributed to the Delegates.)

Michigan Medical Service is proud to report today that we have achieved the best year in our 25-year corporate history. Our membership reached its highest level in seven years. Our operating costs are among the lowest in the nation.

Our fiscal position has never been better and, significantly, we pay out more money to physicians than any other Blue Shield Plan in the nation.

For years we considered ourselves as leaders in advancing the cause of quality health care, consistent with the principle of full service benefits.

Today, any element of doubt is removed based on a national survey of Blue Shield Plans this past year which showed that Michigan physicians were in the front ranks of those Plans providing full service benefits for medical and surgical cases.

This is a notable achievement, made possible by the cooperation and backing of the medical profession.

There are other achievements which I will not take time to enumerate because they are spelled out in the Annual Report in your House of Delegates Handbook, which reports details of Michigan Medical Services activities during the past twelve months. But they are indicative of the contributions that physicians of Michigan are making to improve the quality of care at the lowest possible cost to the patient.

This is your Plan. You founded it, and the men you elect in the House of Delegates set policies as members of our Board of Directors.

We at Michigan Medical Service are cognizant of those contributions, because without them—and without your backing—Blue Shield could not exist.

The House of Delegates can be proud of the men they have chosen in the past twenty-five years because they became leaders in the voluntary prepayment health care system.

Michigan physicians are in leadership roles today as we embark on another quarter-century of service.

Blue Shield Plans across the nation are looking to Michigan for guidance in developing obstetrical and psychiatric programs negotiated by labor and management.

The programs go into effect July 1, 1966. They involve pre- and post-natal care, mental illness care in day and night psychiatric centers and physicians' offices, and other facets of mental health.

Frankly, these programs present many problems, but we don't think they are insoluble.

I repeat that this has been a good year for Michigan Medical Service, but the new year poses problems more challenging than anything in our history.

Medicare is with us, whether we like it or not, and we have less than a year to prepare for it.

Last night, members of this House talked about Medicare pro and con; but the blunt truth is that none of us knows too much about it, and the answers out of Washington are few and far between.

We know that the government means business in terms of utilization control, but we don't know exactly who will be calling the shots for the criteria for quality care.

One thing is certain, and I believe you will agree: Unless physicians take the lead in this important area, we may be taking orders from people far less competent to make medical decisions.

Utilization is only one side of the story. Another side is the question of fees. We are concerned how the government can finance such a program for $6 a month and at the same time pay physicians a fair and reasonable fee for their services.

We are also concerned about Class II services, rendered in a hospital, remaining as a professional benefit.

This House should not take for granted that Michigan Medical Service will be the fiscal agent for Medicare in this State, because nobody has told us so officially.

From a corporate standpoint there are certain advantages if Blue Shield is the fiscal agent. We are geared to such an operation. We have the experience, staff and electronic hardware to handle the claims load which, incidentally, may double or even triple our daily volume of 13,000 claims per working day.

We represent physicians as well as subscribers, and we have done the job for both these past twenty-five years.

For your information, the Board of Directors of Michigan Medical Service has approved a motion authorizing Michigan Medical Service to negotiate for the voluntary portion of Medicare.

At the same time, the Board has directed Michigan Medical Service to seek cooperation from the Michigan State Medical Society in support of these negotiations.

But make no mistake. If you want us to be the fiscal carrier in Michigan—if you want us to be your voice in matters of utilization—we are not talking about a panacea.

Medicare is loaded with fee problems and frustrations. We are also talking about a tremendous job, involving an internal expansion program that will cost hundreds of thousands of dollars.

From the public standpoint, we believe it is our obligation to undertake it and make certain that no individual who wants to be covered will be left uncovered.

We believe it is our public responsibility to develop a scope of benefits to pick up where the Federal Government leaves off, to ensure quality care.

And we have a task force at Blue Shield studying all phases of the program.

But Blue Shield's responsibility does not end with the subscriber. We have obligations to the physicians who make Blue Shield what it is, and we are prepared to fulfill that obligation.

There is one other matter which I would like to discuss briefly. It concerns the Relative Value Study.

We have analyzed the monetary implications of the Relative Values as directed by The Council of the Michigan State Medical Society. Our interpretations are not in depth because of the short time allotted to us.

But at this time we estimate roughly that implementation of the proposed Relative Value Schedule would increase Blue Shield's liability between 16 and 18 per cent a year based on our present payment to physicians.

There may be those in this House today who sincerely believe that Blue Shield can afford this higher fee schedule based on our fiscal position. And I could not agree more that some revisions are in order based on the physician's cost of doing business today.

But as President of Michigan Medical Service, I feel it my duty to tell you that if this Relative Value Study is adopted, the liabilities to our corporation—and it is YOUR corporation—would virtually wipe out our reserve and force us to seek another rate increase, and immediately.

THE REFERENCE COMMITTEE on Medical Service and Prepayment Insurance, J. B. Blodgett, M.D., Chairman, reviewed the Annual and Supplemental Report of Michigan Medical Service recommending acceptance of these reports for information.

It commended Michigan Medical Service for its forward-looking attitude in its Pilot Studies to augment services to the community, such as the Pilot Study in Nursing Home Care and Rehabilitation Care.

It noted, with confidence, the healthy state of the finances of the corporation, but pointed out that the total reserves are not yet enough to cover the cost of the medical services provided the subscribers in a period of two months.

THE HOUSE adopted the report of the Reference Committee.

11. Special Report of Judicial Study Commission

The Speaker stated that because of importance of the subject, this Commission was requested to report directly to the House as a special item of business.

Remarks of Orlen J. Johnson, M.D., Commission Chairman:

Following the recommendation of President McGillicuddy and the action of the 1964 House of Delegates, a Judicial Commission was appointed. The Commission's recommendations for changes in the Constitution and Bylaws of the Michigan State Medical Society were submitted to each county society as well as to the members of this House and The Council. The Annual Report of the Judicial Commission was sent to the same individuals.

The seeming maze of the proposed changes in the Constitution and Bylaws are basically rather simple. A Commission responsible to and elected by the membership shall supervise professional conduct. To avoid cumbersome and delaying legislative processes it shall operate by rules and regulations it promulgates and publishes to meet the needs of proper function under changing circumstances.

These two principles—responsibility to its electorate and freedom from legislative encumbrance—are fundamental for success of this system. The minutiae of nomination, election, representation and districting are less important.

I can say without reservation that this Commission was the most impressive group of physicians I have ever worked with. Their unprejudiced judgment and sincere desire to make a contribution was foremost in all their deliberations. After the principles of a judicial system were concluded, our legal counsel, Lester Dodd, set them down in the proper form before you. To him and the members of our staff we are most grateful.

ANNUAL REPORT OF THE JUDICIAL COMMISSION

O. J. Johnson, M.D., *Chairman*

Resolution No. 11, adopted by the 1964 MSMS House of Delegates, directed that a Judicial Commission be appointed by the President of the Michigan State Medical Society charged with the responsibility of preparing recommendations for providing a permanent Judicial Board and System for MSMS.

The Reference Committee on Constitution and Bylaws of the 1964 House of Delegates, in its Supplemental Report No. 2 on September 22, 1964 proposed an amendment to the MSMS Constitution—a new Article 11—to read as follows: "Article II. Judicial Board. Section 1—Composition, Powers and Duties. The Judicial Board shall be the body having general jurisdiction in matters relating to professional ethics, grievances, discipline of members, utilization of health insurance benefits, and professional conduct generally. It shall consist of members to be elected by the voting members of the Society. The number of members, their terms of office, the time and manner of their election, and the specific powers and duties of the Bord shall be as prescribed by the Bylaws."

The foregoing proposed amendment to the Constitution having been laid over for one year, it is now eligible for adoption by the 1965 MSMS House of Delegates.

The Judicial Commission convened on November 19, 1964. At that time it determined its program and the proper scope of its activities; six months later the necessary MSMS Constitution and Bylaws amendments had been prepared for forwarding to all members of the House of Delegates and officers of component county medical societies for study prior to the 1965 annual session.

In November the Commission, taking cognizance of the creation of a new Council Committee formed solely to consider matters of utilization, determined to proceed with the establishment of judicial principles and to only handle such matters of criteria or use of medical care (utilization) as might be referred to it.

The Commission first established a stated concept of its responsibilities and a statement of its purpose. It then proceeded to set forth its priorities for action and moved into details of procedure. At each step all materials developed were intensively studied in advance of each meeting by all Commission members.

On January 20, 1965, a draft of organizational principles was adopted, supplemented by eight principles of jurisdiction. At the next Commission meeting, held April 7, detailed guidelines for the drafting of specific Constitution and Bylaws language were established for MSMS Legal Counsel. The final recommendations of the Commission to the House of Delegates were reviewed section by section and item by item on June 2, 1965.

The proposed Constitution and Bylaws amendments will be reported directly to the House of Delegates by the Commission Chairman, and have been assigned to the Reference Committee on Constitution and Bylaws by the Speaker of the MSMS House.

The establishment by the Michigan State Medical Society of a permanent Judicial Board and System constitutes a momentous step and is appropriate evidence of the progressiveness and vigor of MSMS on this, its Centennial Year. The Chairman wishes to personally acknowledge with deep appreciation and admiration the conscientious and productive manner in which all members of the Commission entered into their difficult and great responsibilities in this venture. Each and every member, and those of the MSMS staff who provided valuable assistance, have contributed to the development of recommendations for a Judicial Board and System which can be second to none in organized Medicine throughout the United States.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. Tupper, M.D., Chairman, considered the Annual Report of the Judicial Study Commission and the acompanying recommended Constitution and Bylaws changes. The Reference Committee amended the proposed Constitution and Bylaws changes and recommended their adoption as amended.

THE HOUSE, after further amending the proposed Constitution and Bylaws changes, adopted the following amendments to the Constitution and Bylaws.

Add new Article XI to read as follows:

ARTICLE XI—JUDICIAL COMMISSION

Section 1.—COMPOSITION—POWERS AND DUTIES—The Judicial Commission shall be the body having general jurisdiction in matters relating to professional ethics, grievances, mediation, discipline of members, and professional conduct generally. It shall consist of members to be elected by the voting members of the Society, provided, however, that the members of the first Judicial Commission established hereunder shall be selected in such manner as may be provided by the by-laws to serve until their respective successors are elected. The number of members, their terms of office, the time and manner of their election, and the specific powers and duties of the Commission shall be as prescribed by the by-laws.

The present Articles XI and XII of the Constitution to be re-numbered respectively as Articles XII and XIII.

By-Law Amendments

CHAPTER 6

Sec. 1 (e) Amend to read as follows:

(e) is in violation or disregard of the constitution, by-laws, principles, rules, regulations or orders of this Society or of its Judicial Commission or of the American Medical Association, or

Sec. 1. Amend the last sentence to read as follows:

The willful failure or refusal of a member whose conduct has been called into question to appear before any disciplinary body upon request or to cooperate with such disciplinary body or the Judicial Commission in any authorized investigation shall also, in and of itself, be grounds for discipline.

Chapter 6, Sec. 2 to be amended to read as follows:

Sec. 2. Discipline as used in this chapter shall include reprimand, probation, suspension and expulsion, and for grievous offense, recommendation to the State Board of Registration in Medicine of revocation of license.

Sec. 3 to be amended to read as follows:

Sec. 3—DISCIPLINE—WHAT PROCEDURE TO GOVERN—All disciplinary proceedings conducted by this Society or by any component county society, shall be governed by the provisions of this chapter, any provisions of the constitution or by-laws of any component county society to the contrary notwithstanding, until the Judicial Commission shall have made and promulgated rules and regulations governing such proceedings. Upon and after the promulgation of rules and regulations by the Judicial Commission, all such proceedings shall be governed thereby and any provisions of this chapter in conflict therewith shall be of no effect.

Sec. 17 to be amended to read as follows:

Sec. 17—APPEAL PROCEDURE—Any member deeming himself aggrieved by an order of suspension or expulsion may appeal to the Judicial Commission of the Michigan State Medical Society. Notice of such appeal shall be in writing, signed by the appellant and shall set forth specific reasons for his appeal. The notice shall be served on the Judicial Commission and on the appellant's component county society by registered or certified mail, addressed to the respective secretaries thereof. Unless notice of appeal is so served within 30 days following the service on the member of a copy of the order of the suspension or expulsion as herein above provided, such member's right of appeal and review shall be conclusively treated as having been waived and the order of suspension or expulsion shall thereupon become final and effective. On receiving notice of appeal, the component county society shall forward to the judicial commission the complete record of the matter, including copies of the order appealed from, all reports of the Ethics Committee, formal complaint, answer, transcript of testimony, exhibits and all other pertinent writings and data on which the order of suspension or expulsion was based. The Judicial Commission may request the component county society or the appellant to furnish such further information in writing as the commission deems necessary for the proper and full review of the matter. Written arguments may be filed with the Judicial Commission by the component county society and the appellant within 45 days following notice of appeal. The Judicial Commission shall, within 90 days after receiving the full records in the case, review the record on appeal and the written arguments, make such findings as it deems appropriate and, by majority vote of the participating members of the Commission, affirm, modify or reverse the order of expulsion or suspension appealed from, or remand the matter for further action by the component county society. In the consideration of any appeal, not less than six members of the Commission shall participate, and in the event that the participating members of the Commission are equally divided, so that no majority prevails, the order or finding appealed from shall stand affirmed.

A copy of such decision shal be promptly served on the appropriate component county society and on the appellant by registered or certified mail. Unless within twenty days after service on them of a copy of such decision the component county society or the appellant shall take an appeal to the Judicial Council of the American Medical Association, the right to such further appeal and review will be conclusively treated as having been waived, and the decision of the Judicial Commission shall be final and effective.

All appeals now pending before The Council of the Michigan State Medical Society shall be forthwith transferred to the Judicial Commission and the Judicial Commission shall have jurisdiction to hear and decide any such pending appeals.

Sec. 18 to be amended to read as follows:

Sec. 18—APPEAL TO JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION—The appellant, if he was a member in good standing of the American Medical Association at the date of his alleged misconduct, or the component county society may, within twenty days after service of a copy of the final decision of the Judicial Commission, take an appeal therefrom to the Judicial Council of the American Medical Association.

CHAPTER 7

Sec. 4. Add a new Sec. 4 to read as follows:

Sec. 4.—PROCEDURE TO GOVERN—The provisions of this chapter shall be and remain in effect until such time as the Judicial Commission shall have made and promulgated rules and regulations governing mediation procedures. Upon and after the promulgation of rules and regulations by the Judicial Commission governing mediation committees and procedures, all such committees and procedures shall be governed thereby and any provisions of this chapter in conflict therewith, shall be of no force and effect.

Add new Chapter 11 to read as follows:

CHAPTER 11

THE JUDICIAL COMMISSION

Sec. 1—COMPOSITION-QUALIFICATIONS—The Judicial Commission shall be composed of ten members, each of whom shall be a voting member of the Society in good standing. Provided, however, that the members of the present Judicial Commission, shall constitute the Judicial Commission, and shall have all the powers, duties and authority thereof until their successors shall have been elected in the manner prescribed by these Bylaws.

Sec. 2.—JUDICIAL DISTRICTS—There shall be seven Judicial Districts formed by grouping component county societies as follows:

District #1—Wayne.

District #2—Macomb, Oakland, St. Clair.

District #3—Ingham, Livingston, Monroe, Shiawassee, Washtenaw.

District #4—Bay-Arenac-Iosco, Genesee, Gratiot-Isabella-Clare, Huron, Lapeer, Midland, Saginaw, Sanilac, Tuscola.

District #5—Allegan, Berrien, Branch, Calhoun, Cass, Eaton, Hillsdale, Jackson, Kalamazoo, Lenawee, St. Joseph, Van Buren.

District #6—Barry, Clinton, Ionia-Montcalm, Kent, Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana, Ottawa.

District #7—Alpena-Alcona-Presque Isle, Chippewa-Mackinac, Delta-Schoolcraft, Dickinson-Iron, Gogebic, Grand Traverse-Leelanau-Benzie, Houghton-Baraga-Keweenaw, Luce, Manistee, Marquette-Alger, Menominee, North Central Counties (Crawford, Gladwin, Kalkaska, Montmorency, Ogemaw, Oscoda, Otsego, Roscommon), Northern Michigan (Antrim, Charlevoix, Cheboygan, Emmet), Ontonagon, Wexford-Missaukee.

Sec. 3.—NOMINATIONS—On or before September 25th in the year 1965 and on or before July 15th in each succeeding year, the Chairman of The Council shall, with the advice and consent of The Council, appoint a Nominating Committee composed of seven members of The Council. Such Nominating Committee shall select from the voting members in good standing of the Society in each Judicial District at least twice as many nominees for the office of Judicial Commissioner as are to be elected in such year from such district. After obtaining the consent of such nominees to become candidates, the Nominating Committee shall submit its list of nominations to the Secretary of the Society on or before October 15th in the year 1965 and on or before September 1st in each succeeding year. Within ten days thereafter, the Secretary of the Society shall post a list of such nominations in a conspicuous place in the headquarters building of the Society and shall mail a list of such nominations to the secretary of each component county society and shall give notice to the secretary of each said component county society that the voting members of this Society within the several Judicial Districts have the right to make additional nominations by petition as hereinafter set forth. Promptly upon receipt of such notice and list of nominations, the secretary of each component county society shall make such nominations known to the voting members thereof in such manner as shall be determined by the component county society. Additional nominations may be made by petition signed by not less than twenty-five voting members in good standing in any Judicial District. Such nominating petitions shall be filed with the Secretary of this Society not later than November 25th in the year 1965 and not later than October 15th in each succeeding year.

Sec. 4.—BALLOT-ELECTION—Under the direction of the Secretary of the Society, separate ballots, in such form as shall not identify the voter, shall be prepared for each Judicial District from which a member of the Commission is to be elected. On or before December 15th in the year 1965 and on or before November 10th in each succeeding year in which a member of the Commission is to be elected from such district, the Secretary of the Society shall mail a ballot containing the names of all nominees, arranged in alphabetical order, to each voting member in good standing of the Society in such Judicial District. Ballots shall be marked and returned to the office of the Society not later than December 30th in the year 1965 and not later than December 1st in each succeeding year and any ballot bearing postmark later than such date shall not be counted. Each ballot, to be valid, must be voted for neither a greater nor a smaller number of nominees than are to be elected from such district at such election. The ballot furnished to voting members shall have printed upon it a copy of the last preceding sentence.

The valid ballots so cast shall be tabulated and the results certified by an independent service agency under the supervision of the Secretary of the Society. In case of a tie vote, the winning candidate shall be determined by lot under the supervision of the Secretary. Those elected shall be notified by the Secretary and the names of those elected shall be made known to the members of the Society through publication in the Journal of the Society or by such other means as shall be directed by The Council.

Sec. 5.—TERMS OF OFFICE—At the election held in the year 1965, four members of the Commission shall be elected from District #1, and one each from Districts #s 2, 3, 4, 5, 6 and 7. At the first meeting of the Commission following the election in 1965, it shall be determined by lot that two of the members elected from District #1 shall serve for a term of three years each, one for a term of two years and one for a term of one year. Thereafter, one member of the Commission shall be elected annually from District #1 to serve for a three-year term, provided, however, that in the year 1968 and each third year thereafter, two members shall be elected from District #1 to serve for terms of three years each. It shall also be determined by lot at such meeting that two of the members elected from Districts #s 2, 3, 4, 5, 6 and 7 shall serve for terms of three years each, two for terms of two years each and two for terms of one year each. Thereafter, one member of the Commission shall be elected annually from each of Districts #s 2, 3, 4, 5, 6 and 7 in which an elective term expires, such election to be for a term of three years.

Sec. 6.—VACANCIES—Whenever a vacancy occurs as the result of the death or resignation of a Commissioner or from any other cause, the President of the Society shall have the authority, acting with the advice of the Councilors of the Judicial District affected, to appoint a Commissioner from the district affected, such appointee to serve until the next election of Commissioners at which time a Commissioner shall be elected to serve for a remainder of the unexpired term.

Sec. 7.—ORGANIZATION OF THE COMMISSION—The Commission shall meet as soon as feasible after each annual election and at such meeting select a Chairman, a Vice-Chairman and such other officers as may be deemed desirable. The terms of such officers and their duties and responsibilities shall be as determined by the Commission.

Sec. 8.—POWERS AND DUTIES—The Judicial Commission shall have:

(a) Authority to make binding interpretations of the constitution and by-laws of this Society and of the several component county societies as they pertain to matters of ethics, mediation, grievance and discipline.

(b) Authority to make ethical interpretations and decisions in accordance with the standards of the American Medical Association.

(c) Sole appellate powers at the state level in all matters relating to ethics, professional conduct, mediation and discipline of members of component county societies.

(d) The power to entertain and exercise original jurisdiction in matters pertaining to ethics, mediation, conduct of members or discipline of members when requested to do so by any component county society or by any member in good standing of this Society.

(e) The power and authority to make and promulgate, from time to time, rules and regulations governing all procedures pertaining to ethics, grievances, mediation, professional conduct and discipline of members, which rules and regulations shall be binding upon all component county societies.

(f) The power and authority to appoint such committees and to adopt such rules, regulations and procedures as, in the sole judgment of the Commission, are deemed desirable in carrying out the functions and purposes of the Commission.

Renumber present CHARTER 11 of the by-laws as CHAPTER 12.

Repeal subdivision (e) of Sec. 1 of present CHAPTER 11. Renumber subdivision (f) of Sec. 1 of present CHAPTER 11 as subdivision (e).

Repeal subdivision (g) of present Sec. 1 of CHAPTER 11. Renumber subdivisions (h), (i), (j) and (k) as subdivisions (g), (h), (i) and (j) of Sec. 1 of CHAPTER 11 of the present by-laws.

Renumber present CHAPTERS 12, 13, 14, 15, 16 and 17 as 13, 14, 15, 16, 17 and 18, respectively.

REPORTS OF THE COUNCIL

12. Remarks of Council Chairman—H. H. Hiscock, M.D.

Nineteen sixty-five has been a momentous year.

The annual report of The Council, which is in your Handbook, outlines briefly some of the major actions and activities for which The Council provided leadership; I won't elaborate on those now. Vice Chairman Mason of The Council and I will be present at the reference committee meeting to furnish necessary additional information.

One of the primary goals of The Council this year was to inform and unify the medical profession so that forthright and effective positions could be communicated to the public and to our legislators on the many pieces of legislation that affect the health of the people.

On the national level, medicine and the many supporters of medicine's position were not successful in opposing the Social Security approach to financing health care of the aged. But on the State level, despite myriad problems, we did succeed in communicating our positions.

The Council is proud of the support received from component societies, Delegates and Alternate Delegates, and the Michigan State Medical Society staff. I wish to personally praise these past efforts and to remind you that what has now begun must continue on a year-round basis. Your contacts must be nourished and maintained. The effectiveness of our legal affairs staff will be in direct proportion to the extent of your hometown effort.

You can see how important are the efforts of the individual—your efforts. We need this help also on our many committees. If you have any suggestions for men who would be interested in serving, please send them to me or the President. We are always looking for new and interested men.

This week marks the Centennial of the Michigan State Medical Society, and I would like to commend our committees and staff under the leadership of General Chairman C. Allen Payne, M.D., Executive Director Hugh Brenneman, and Associate Executive Director Warren Tryloff for the fine array of events and programs that have been planned with detailed care.

My main purpose in addressing you today is to inform you of the actions of The Council taken at its meetings this past Saturday and Sunday. These are not contained in our printed annual report.

Medicare is now a fact. The Council has tried to keep abreast of rapid developments in the implementation of this legislation. Rules and regulations are being interpreted almost daily on both a national and state level. The Council has established liaison with the Governor and the heads of his three principal departments regarding Michigan implementation of Medicare.

In order to gain information in more depth, The Council is attending a special briefing session in Chicago next week. The AMA is sponsoring this orientation on Medicare for AMA delegates and state officers. It will be a day-long meeting with representatives of Health, Education and Welfare.

Many questions about Medicare still are unanswered. The answers to some of these may have a bearing on the question of who shall be the fiscal agent in Michigan. The Council has asked a committee of its members to try to obtain some of these answers this week. It therefore has no recommendation to make to the House on this subject at this moment. The House may wish to take action on this based on the latest information available tomorrow and Tuesday.

The law mentions that reasonable fees will be paid to physicians. Just what the Department of Health, Education and Welfare will consider a reasonable fee has not been determined, nor is it clear at this point how this will be decided—by negotiation or dictum.

Medicare implementation is extremely complex. Our involvement and concern with many State and governmental agencies is ever increasing, added to our constantly expanding interest and effort in the legislative process.

Because of these factors, The Council is recommending an addition to our staff if financing can be obtained. Such a staff person, who might be a physician, could handle our relationships with government health programs. This recommendation could lead to a considerable increase in our staff activity, with a resulting increase in expense. To offset it, a dues increase would be required, and this could be as much as $15. Our Finance Chairman will speak of this in just a moment.

If we expand our staff for this purpose, I think we must explain to the public that we are doing this voluntarily in order to cooperate most effectively with the law of the land in the best interest of our patients.

Last year the House directed a continuation of the Relative Value Study. The Committee has worked terribly hard and its report is before you. When the copies were sent out by The Council, each was marked, "This copy submitted for information and review only. It has not been acted upon by the House of Delegates and is not official."

The Council has approved the study as complying with the 1964 House instruction and now refers it to you "to develop necessary policies for its implementation."

The Council makes no recommendation to the House regarding monetary unit values. The Council agreed to study and consider the designation for 1965 of a $5 monetary value per unit as being representative of usual and customary fees in the 1965 RVS but has not completed its study and is not making any recommendation at this time.

Now I would like to call upon C. Allen Payne, M.D., Chairman of the Finance Committee, to review the latest information on the finances of our Society. Dr. Payne.

C. ALLEN PAYNE, M.D.: Mr. Speaker and Members of the House of Delegates:

It is a pleasure for me to summarize the financial status of our Society, carrying us through nine months of the current fiscal year. You have received a copy of the current financial statement to September 1, 1965, and also a summary of the liquid and fixed assets of our Society.

Among our assets you will note savings on deposit at the Michigan National Bank in the amount of $63,072.92 and United States Savings Bonds and interest in the amount of $64,106.71.

The financing of the Headquarters building has been reported each year since construction began. At the end of fiscal 1961 outstanding notes payable to the Michigan National Bank totaled $200,000. At the end of fiscal 1964 outstanding notes totaled $100,000. As of September 1, 1965, outstanding notes totaled $35,000.

However, as in the past, it will be necessary to reborrow during the closing months of this year and repay in the early months of 1966 when dues income is high. By this arrangement it has been possible to save the Society from $2,000 to $4,000 annually in interest charges.

Also, during the balance of the fiscal year it may be necessary to draw on our Savings Reserve Account to support certain non-recurring expenses in connection with the Michigan State Medical Society Centennial previously authorized by this House of Delegates. I believe our Society is in sound financial condition.

Last year I reported on the possibility of proposed new Internal Revenue Service regulations concerning unrelated business income. Since that report there have been no new developments in this field.

The report of the tax consultants who were employed (mentioned in my previous report) indicated, however, that significant advances can be made in our Society's financial planning and reporting procedures without radical revision of the accounting system. The Finance Committee and The Council have under consideration a detailed report from the tax consultants which will accomplish this objective.

I should like to add a note about future activities, one of which Dr. Hiscock has already mentioned, namely, the increased staff work necessary to attempt to unravel the multitudinous details in connection with the Medicare law. In addition, the increased legislative activity which we have experienced during the current Session of the State Legislature, and which can be similarly projected into the next two or three years, may require additional staff or curtailment of other Society activities. If either or both of these activities are to be improved by the House, it will be necessary to secure additional income to keep our organization financially sound. Our only continuing source of income is from dues.

Depending upon the amount of increased activity voted by the House, it may be necessary to recommend an increase in dues by as much as $15 a year. Myself and members of the Finance Committee will be glad to be available for any consultations with any reference committees or with individual members of this House.

Thank you very much.

H. H. HISCOCK, M.D.: The Council also yesterday at the session recommended the special report by the Chairman of the Joint Committee on Medicine and Osteopathy.

J. I. COURY, M.D.: The Michigan State Medical Society has completed a century of dedication and progress. Each doctor of medicine can be justly proud of these past 100 years. Through its dedication and research, Michigan medicine has given to its fellow man medical care second to none. We are about to embark on our next 100 years. Are we ready, willing and able to accept the challenge? I say yes! Will we continue to progress? Definitely yes!

Five years ago the Michigan State Medical Society accepted the challenge offered by separate schools of medical practice and embarked on a study of the relationship of medicine and osteopathy, with the prime objective to do what is best for the people of Michigan. Out of this has come a better understanding of our osteopathic physicians.

It is now an established fact that there is a closer association and understanding with the practicing doctors of osteopathy. There has been the formation of joint staff hospitals and the invitations to doctors of osteopathy to attend excellent postgraduate educational studies so that the people of Michigan can be better served.

Last year your House of Delegates directed immediate study and exploration of all avenues toward eventual merger of medicine and osteopathy. This is being done. Your progressive action for better health care for the people of Michigan is being vigorously supported by the great majority of doctors of medicine and doctors of osteopathy.

Unfortunately, roadblocks are being thrown up by those who are attempting to influence the legislature to develop a college of osteopathy. But of even greater importance than the dollars involved is the incalculable harm that the establishment of such a school would do by way of interrupting the steady progress that is being made toward understanding and amalgamation.

Negotiations in this field are necessarily delicate and can be easily disrupted. Certainly the establishment of a new osteopathic school would be such a disruptive factor as to seriously impede and delay any form of integration.

The position of medicine is based on its concern for the welfare of the citizens of this State. It recognizes all too clearly that an osteopathic school would (1) impede the amalgamation of medicine and osteopathy, (2) continue and promote unnecessary duplication of facilities, and (3) fail to provide for the education of the essential health teamworkers other than physicians.

Remember, for every physician, twelve paramedical personnel must be trained. This is something that the osteopathic organization has not done in the past. The medical organizations have been training paramedical personnel for the osteopathic physicians. We do not feel that an osteopathic college could promote and develop a paramedical team.

Michigan State Medical Society is committed to the best health care possible for the people of Michigan. With this purpose we must then do all humanly possible to resolve the problems of medicine and osteopathy. This we must do expediently.

If these problems are to be resolved in the near future, then Michigan medicine with the help of a majority of progressive DOs and the people of Michigan must do everything possible to enlighten our public representatives in Lansing. Such enlightenment can prevent the waste of public funds to build an inadequate and divisive institution that would not make for better health care but would aid in depriving the people of Michigan of the best in medical care.

We must and will accept the challenge. We must pledge to the people of Michigan our continuing efforts to protect their best interests. To this end we must cooperate with the osteopathic physicians. Amalgamation of the two professions in the near future is in the best public interest. We insist that the health care of the people of Michigan is paramount. Compounding a dichotomy in care is detrimental to this objective.

Thank you, gentlemen.

H. H. HISCOCK, M.D.: Mr. Speaker, this completes my report.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander Blain, III, M.D., Chairman, approved the Council Chairman's remarks and noted "that if additional staff is required necessitating a further increase in dues, that further study of our budget be required," and recommended that "the matter be referred at this Session to the Ways and Means Committee." The Reference Committee complimented The Council and its Chairman "on the monumental work accomplished during this past year."

THE HOUSE adopted the report of the Reference Committee.

THE REFERENCE COMMITTEE on Ways and Means, W. K. Locklin, M.D., Chairman, reported as follows:

"The Reference Committee considered the paragraph in the Council Chairman's Remarks which reads as follows: 'Medicare implementation is extremely complex. Our involvement and concern with many State and governmental agencies is ever increasing, added to our constantly expanding interest and effort in the legislative process. Because of these factors, The Council is recommending an addition to our staff if financing can be obtained. Such a staff person, who might be a physician, could handle our relationships with governmental health programs. This recommendation could lead to a considerable increase in our staff activity with a resulting increase in expense. To offset it, a dues increase would be required and this could be as much as $15.'

The Reference Committee report continued,

"The additional funds, if voted by this House of Delegates, will provide greatly needed and urgent action in three areas: (1) Liaison with governmental agencies in the implementation of Medicare; (2) improved legislative contact with the State legislature; (3) increased community relations activity. In view of the urgency and lack of specific budget, the Reference Committee recommends an arbitrary increase in the annual dues of $10."

THE HOUSE adopted the report of the Reference Committee.

14. Annual Report of The Council

PART I

Report of Council Activities

This section of the report contains a brief review of the activities and actions of The Council covering the period from September, 1964, to September, 1965.

Minutes of the monthly meetings of The Council are distributed to component medical societies and members of the House of Delegates. In addition, abstracts of Council actions appear monthly in *Michigan Medicine*. For this reason, the details of Council actions and decisions are not outlined in this review. Instead, The Council wishes to point to a few of the major successes and problems in a general way.

Judicial Commission. Progress reports from the Judicial Commission were reviewed with commendation by The Council. Its final report will be given directly to the House of Delegates because of the importance of this study.

Legal Opinion. During the year Legal Counsel Lester P. Dodd has rendered approximately 50 written opinions. A larger number of informal opinions were given on a wide range of subjects regarding the activities of the Society and the interests of its members. Mr. Dodd attended meetings of the House of Delegates, The Council, many committees and the Annual Session. Mr. Dodd counselled with and advised officers and members of the staff in almost every facet of the Society's activities.

Advice of Legal Counsel was especially valuable to the Judicial Commission, the Legal Affairs Committee and the House of Delegates Committee on Constitution and Bylaws.

Appointment to Fill Vacancy on The Council. The Council accepted with regret the resignation of Councilor Edgar E. Martmer, M.D. The Wayne County delegation nominated Ralph R. Cooper, M.D., to serve as Councilor from the First District, replacing Doctor Martmer, "until the next meeting of the House of Delegates, when the House shall elect a successor to fill the unexpired term."

Ruling of AMA Judicial Council. As recommended by The Council and approved by the 1964 MSMS House of Delegates, the AMA Judicial Council was requested to render a formal opinion regarding the propriety of physicians using prescription blanks containing printed advertising of a pharmacy or drug store. On September 26, 1964, the Judicial Council adopted the following ruling: "It is unethical for physicians to use prescription blanks with the name of a pharmacy printed thereon."

Training of Family Physicians. Several times during the year The Council expressed its continuing concern regarding the quantity of family physicians and the efforts of Michigan's two medical schools in supplying these family physicians. The deans of the two schools were invited by The Council to comment on their current plans and appraisal of the situation. In addition, the Society's Committee on Rural Medical Service has concerned itself with the problem of the declining supply of general practitioners. No definitive solution was reached but The Council is still studying the matter and attempting to provide leadership in working toward a solution.

Active Membership in a County Society Without Membership in the State Society. At the request of The Council in December, 1962, Legal Counsel provided an interpretation of the MSMS Bylaws, Section 1 of Chapter 2, "that active members of this Society shall comprise all the active members of the several component county societies." Legal Counsel concluded that one cannot be an active member of the component society without being a member of MSMS. The Council adopted this interpretation of the Bylaws.

Since then, however, an occasional question on this point has been raised to The Council by individual physicians who did not so interpret the MSMS Bylaws. In October, 1964, The Council reaffirmed its interpretation of the MSMS Constitution and Bylaws on this point, but recommends to the House of Delegates the adoption, at the next Annual Session, of such express clarifying amendments to the Bylaws as will permit no possible misinterpretation of this basic requirement. In implementing this decision The Council has referred to the Standing Committee on Constitution and Bylaws development of the proposed clarifying amendment.

Proposed Creation of MSMS Affiliate Membership Classification. It was brought to The Council's attention that the AMA had established an affiliate membership, without dues, so that friends of medicine and non-M.D.'s in related professions could become affiliate members of AMA. It was proposed by one of The Council's Committees that a similar membership classification be created by MSMS, since this might well serve to expand medicine's influence and understanding among non-physicians. Upon recommendation of the Committee, The Council did approve the basic idea of an affiliate membership with the following ground rules and methods of implementation:

"Affiliate memberships may be initiated at the component medical society level from which recommendations for affiliate membership are made to The Council of MSMS, or they may be initiated by The Council in the first instance."

The Council noted that since AMA had created this membership classification, dentists, veterinarians and others interested in the goals of medicine were responding to this membership opportunity.

The Council referred these actions to the Standing Committee on Constitution and Bylaws for development of an amendment following the language of the American Medical Association Constitution and Bylaws with respect to affiliate membership. These amendments will be presented to the House of Delegates by the Standing Committee on Constitution and Bylaws.

Separation of Nursing Home Day Rates and Fees for Physicians' Services and Medicine. In response to a proposal by the Michigan Nursing Home Association that daily rates be adjusted to include fees for physician services and medicine, The Council recommended to the House of Delegates adoption of a policy that "all fees for physicians' services and medicines be kept entirely separate from day rates for nursing home care, since the establishment of an all-inclusive rate might lead to poor and inadequate medical care and tend to separate the patient from his family physician."

(See Council recommendation in Part IV of this report.)

MSMS Participation in Voluntary Hospital and Facility Planning. In December, 1964, The Council began its study of a Michigan Plan for voluntary planning of hospitals and health facilities. A Hospital Research and Educational Reserve, Inc., was being formulated. MSMS, along with other health-oriented organizations, was asked to participate both financially and in the Reserve's Health Facilities Planning Council. The Council directed its Hospital Relations Committee to give intensive study to the possibility of MSMS participation and, acting upon the recommendation of the Committee, subsequently agreed to become a member of the Reserve, and appointed MSMS representatives to the membership, the Executive Committee and the Health Facilities Planning Council. Based upon its membership, MSMS financial participation amounts to $3,000 per year.

Michigan Health Fair. The 1964 House of Delegates authorized The Council to continue its preliminary plans for the 1966 Michigan Health Fair and authorized it to take necessary steps to seek the required financial assistance from outside sources. Immediately following the House of Delegates meeting, The Council, through its Health Fair Arrangements Committee, revitalized its drive for funds and in December, 1964, indicated that $97,100 had been committed by various firms and groups throughout the state, either in cash or by verbal commitment. This amount was short of the goal. (The Council had set December 16 as the deadline for the solicitation drive report and felt it necessary to make a decision regarding the feasibility of continuing this project at that time. The Council thoroughly reviewed the project at its December 16 meeting.)

As plans for the Fair progressed, it became more and more difficult to predict the precise costs, and it was concluded that the current budget of $146,000 might not cover expenses. Then, too, advice of Detroit tax consultants indicated the necessity of having a charitable organization receive and disburse Health Fair funds. The tax consultants suggested that the Michigan Health Council or the Michigan Foundation for Medical and Health Education would be the acceptable vehicle for such financial administration.

After reviewing all aspects of the Health Fair project, The Council came to the reluctant conclusion that the project as an MSMS effort should be discontinued. Subsequently, the Michigan Health Council's Board of Directors expressed interest in the project and is continuing exploration of its potential.

Participation in AMA Teletype Network. The Council authorized MSMS participation in the AMA teletype network to provide faster communication with the AMA and other state medical societies participating in the network. Installation and maintenance costs are borne by the AMA.

Charge to Dues-Exempt Members for Michigan Medicine. The Council noted that 1,000 copies of *Michigan Medicine* were being distributed to dues-exempt members of MSMS at no cost to them. The Bylaws provide that The Council may determine the subscription costs for *Michigan Medicine* for dues-exempt members. Noting that this free distribution contributed substantially to the loss reported for the publication of *Michigan Medicine,* The Council authorized its termination and established a subscription rate of $6.00 per year, effective March 1, 1965.

Finance. All departments are being operated to fulfill the aims and purposes of MSMS. All committees are maintaining their activities within their budget allocations. The reserve of $57,000 in Government bonds has been maintained.

In addition, a Savings Reserve account now totals (as of June 30, 1965) $62,793 on deposit at the Michigan National Bank. This account is retained as a liquid reserve for contingencies. It may be necessary to draw from this account to support certain non-recurring expense in connection with the MSMS Centennial.

The financing of the headquarters building has been reported each year since construction began. On July 1, 1965, we had notes due in the amount of $10,000. However, as in the past, it will be necessary to re-borrow during the closing months of the year and re-pay in the early months of 1966 when dues income is high.

At the end of fiscal 1961, outstanding notes totaled $200,000.
At the end of fiscal 1962, outstanding notes totaled $150,000.
At the end of fiscal 1963, outstanding notes totaled $125,000.
At the end of fiscal 1964, outstanding notes totaled $100,000.

(A supplemental presentation on the detailed financial income and outgo of MSMS will be made by Finance Chairman C. Allen Payne, M.D., to the House of Delegates in September.)

American Medical Association Education and Research Foundation. On behalf of MSMS, The Council authorized a check to be drawn to Wayne State University School of Medicine for more than $11,000 and to the University of Michigan Medical School for more than $17,000. A public presentation of the checks will be made subsequently.

Implementation of Medicare Program. The Council gave extensive study and discussion to all phases of the possible implementation of the Medicare program. It was recommended that any contract bargaining should be done by medical organizations and not by fiscal agents—Blue Cross, Blue Shield, or private companies. The Council forwarded a letter to the American Medical Association presenting the MSMS position that medical organizations should be the bargaining units for benefits and services under Medicare.

In July The Council appointed a committee to work with the Liaison Committee with the State Executive Office in helping to shape the plans for the implementation of Medicare by the various Michigan governmental agencies.

Establishment of MSMS Program for Research and Development. The Council requested the Committee on Medical Socio-Economics to formulate plans for expanding MSMS efforts in research and development programs. Information re the Committee's progress in this area is contained in its Annual Report.

Life Membership. The Council considered the question of life membership in MSMS as it might relate to life membership in a component medical society. MSMS Legal Counsel provided the opinion that the MSMS Bylaws clearly state that life membership in MSMS and life membership in a component county medical society are entirely separate and the details with respect thereto are at the discretion of each. Therefore, The Council felt that no further action was necessary as long as the point was clarified that an MSMS member could be a life member of one without necessarily being a life member of the other.

Nursing. Through its Committee on Nursing, The Council endorsed a general statement and specific definition of nursing functions. The statement was also approved officially by the Michigan State Nurses Association. These recommendations are not designed to train nurses to practice medicine, but to better qualify them to render emergency service.

Membership. Total membership in MSMS as of June 30 and as of December 31, from 1935 to 1965, is indicated in the following chart:

Year	June 30	December 31
1935	3410	3543
1945	4425	4686
1955	5503	6109
1960	6660	6715
1962	6776	7018
1964	6954	7294
1965	7247	

Total membership November 30, 1964 was 7,294 (Active—6,314, Exempt—980).

Relations—Professional, Public, Legislative and Prepayment Plans

The annual report of the Public Relations Committee tells the work of the Society in the field of public relations. This report of The Council recaps only a few of the ventures this past year which consumed considerable attention of Council members and MSMS staff.

MSMS Efforts re Eldercare and Medicare. All channels of communication were used by MSMS to inform the public about the advantages of the AMA Eldercare approach as against the shortcomings of the Administration's Medicare proposal. Educational ads were placed in each of Michigan's 362 daily and weekly papers and special messages were carried by virtually every radio and television station. MSMS spokesmen appeared before numerous meetings of state-wide organizations and local groups. During the peak of the efforts in the spring, 244,568 pieces of literature were sent by MSMS to Michigan physicians for distribution to their friends and patients. For further details, see the PR Committee comments.

Reaching the Public through the Press. For the first time in five years, MSMS sponsored a Medical Writers Conference. This successful conference, held at Michigan State University, drew representatives from most of the larger Michigan dailies and several influential weeklies. It helped improve understandings on the part of both doctors and newspapers.

Telling the Public through Radio and Television. MSMS is proud of its frequent involvement in two excellent weekly television programs which reach millions of viewers each year. Produced by the Michigan Association of the Professions, "Formula," a half-hour dramatized interview program, was offered over WJIM-TV, Lansing. MAP with the Michigan Health Council also telecast the quarter-hour program "Decision, the Moment of Truth," over WJBK-TV, Detroit.

A fine series of radio tapes continues to be carried each week by 38 stations in Michigan, Ontario and Ohio, under the direction of the MSMS Committee on Scientific Radio and Television and through the technical production of WUOM on the University of Michigan campus.

These are by no means the complete scope of the MSMS public relations thrust. Attention is invited to the two campaigns—Measles Immunization and Community Health Week—in the Annual Report of the MSMS Public Relations Committee, which also reviews the following projects: career recruitment, liaison with other professions, liaison with the Woman's Auxiliary and Medical Assistants Society, Officers Conference, publication by MSMS of AID Newsletter, distribution of health pamphlets, legislative dinners, field service to county societies, MSMS awards program, motion pictures, speakers and PR articles in *Michigan Medicine.*

Medical Information for 1966 Michigan Driver's Licenses. The 1964 House of Delegates recommended that medical information, particularly re tetanus immunization, be placed on Michigan driver's licenses if possible. Investigation through the Highway Accident Prevention Committee and the Secretary of State's office disclosed an opportunity for MSMS to provide doctors with stickers which may be filled out with pertinent medical data and placed on the driver's licenses of their patients. Stickers are required because the new licenses will be laminated plastic. MSMS is identified on the sticker and 1,000,000 stickers were obtained at cost through the Secretary of State's office. These stickers will be made available to physicians.

Liaison with Michigan Health Council. The Michigan Health Council continues to expand its Professional Placement Program. During the past year it has been responsible in whole or in part for the placement of 71 doctors of medicine, 25 doctors of dentistry and 6 doctors of veterinary medicine.

The Health Council has promoted coordinated home care, and there are currently nine home care programs in operation in the State.

It has produced in the past year more than 125 television programs on health and medicine which have covered two-thirds of the State's viewing audience.

Its Health Careers Recruitment Program has continued to expand. In August of 1964, a special project, including a Teacher's Guidebook on Smoking and its Relationship to Health, was developed with the Council serving as the coordinating agency.

The Health Council has also worked closely with more than 70 school health councils and community health councils throughout Michigan. Many of the local health councils participated in Community Health Week in Michigan during October, 1964, which was jointly sponsored by MSMS, the Michigan Health Council, and the Michigan Association of the Professions.

Legal Affairs. A major segment of The Council's deliberations has been the Legal Affairs Committee's recommendations and reports during 1965. This has been one of the most active legislative periods in recent years. The State Legislature, after a summer recess, will return to Lansing and resume its work in the fall, thus necessitating The Council's attention to legal affairs matters throughout the entire year.

Continuing issues which will require Council guidance include implementation of the reorganization of governmental agencies and the activity of the Legislature to study the feasibility of the creation of a school of osteopathic medicine in Michigan. Under Michigan's new Constitution, legislative proposals introduced in 1965 and not acted upon may still be considered in 1966. The Council notes that legislative activities can no longer be confined to a portion of each year but must continue unabated throughout the entire year.

The Council, in April, called an Emergency Conference on State Health Legislation in Lansing. This educational meeting enlisted the wholehearted support of the MSMS members attending, and high praise is due the physicians who subsequently carried out a most effective local contact program.

Medical Aid Station at Capitol Building. MSMS' highly successful project, in cooperation with the physicians of the Ingham County Medical Society, to provide a medical aid station in the Capitol Building for members of the State Legislature was again operative during 1965. MSMS defrays the expense of a staff nurse and local physicians volunteer to serve in emergencies and take referred calls. The Council once again expresses its appreciation to the Ingham county physicians who participate in this worthwhile service to lawmakers.

Reports of Michigan Medical Service. At each meeting of The Council, the President of Michigan Medical Service presented a review of matters of mutual interest.

Liaison with the Michigan Association of the Professions. MSMS has continued to profit by this liaison. MAP's Annual Congress of the Professions held during "Professional Week" presented, in addition to other nationally known physicians, Dr. Donovan F. Ward, President and Dr. F. J. L. Blasingame, Executive Vice President of the American Medical Association. Resolutions were passed supporting medicine's policies.

MAP joined the MSMS and the Michigan Health Council in sponsoring "Community Health Week" and the statewide "Get Out the Vote" campaign.

Twenty-seven doctors appeared on the weekly MAP-MHC television program "Decision, The Moment of Truth" (Channel 2, Detroit). Thirty-nine doctors appeared on the weekly MAP television program "Formula" (Channel 6, Lansing). Combined, these television programs reach 250,000 persons each week. The 37 programs devoted to medicine in 1964 were valued at $123,950.

MONITOR, monthly publication of MAP, carried information on MSMS to members of other professions and vice versa. Hundreds of physicians have taken advantage of MAP's business services.

MAP-type organizations have been formed in eight other states and the AMA House of Delegates, in June, 1965, officially recommended the organization of MAP-type associations and the American Association of the Professions.

Postgraduate Education

Annual Session. The 1964 Annual Session in Detroit made extensive use of panel presentations with considerable involvement of the audience rather than the short didactic lectures. The Breakfast Discussion Sessions, again using panels, also proved popular.

1965 Centennial Session. For the first time, the MSMS Annual Session will be held in Cobo Hall. The scientific program activities will begin Tuesday noon, September 21, and continue through Friday. The exhibits will open at noon Tuesday and close at the end of Thursday's program. The Scientific Program Committee has obtained 132 outstanding medical authorities to speak. In addition to the physicians from Michigan, the program personnel will represent medical schools, hospitals, agencies and laboratories in Pennsylvania, Colorado, Georgia, California, New York, Illinois, Minnesota, Louisiana, Missouri, Ohio, Wisconsin, Connecticut, Florida and Washington, D. C. The major new teaching technique at the Annual Session will be clinical demonstrations in the exhibit area of Cobo Hall. Twenty demonstrations will be presented. Other successful educational media—such as closed-circuit color television, breakfast discussion groups, luncheon meetings, general assemblies, specialty programs, etc.—will all be continued. Category I credit will be given Wednesday, September 22, to members of the Michigan Academy of General Practice who attend.

Co-sponsorship of the Diet Therapy Conference. In previous years, the Michigan Department of Health and the Michigan State Medical Society have co-sponsored a Diet Therapy Conference as part of the postgraduate effort. A similar meeting is planned for 1965, The Council feeling that such a meeting would enhance the Centennial Session and should be held concurrently with it. During the Centennial, other conferences also are planned, such as the Friday morning event that will stress preventive medicine. Many of the subject matter conferences at the Centennial will be sponsored by MSMS sections, often in cooperation with specialty organizations.

MSMS Postgraduate Lectures. The offerings of the MSMS Postgraduate Education Committee were expanded this past year. After a pilot 1965 program at Midland, the Committee added an afternoon hospital clinical conference to the usual evening PG lecture during the spring at Port Huron, Marquette and Kalamazoo in addition to Midland. This new venture in postgraduate education was well received and is being recommended for this fall. In addition to the four afternoon-evening programs, MSMS presented lectures primarily by university medical educators at 20 county society meetings in the fall of 1964 and again in the spring of 1965. In the spring of 1965, 47.4 per cent of the physicians in the areas served by the PG program attended the meetings, a gain over the 39.5 per cent figure of a previous year. These MSMS lectures are possible through the cooperation of the Medical Schools at the University of Michigan and Wayne State University, and the State Department of Health.

Annual Conference on Maternal and Perinatal Welfare. A total of 232 physician registered from 32 different counties for this postgraduate education activity of the MSMS Maternal Health Committee. The two-day conference was held for the first time at Flint, with the cooperation of the Clara Elizabeth Fund. A smaller spring conference was held by the Committee at Gull Lake when physician-consultants from various areas of the state assisted with case studies.

Michigan Medicine, the Journal of the Michigan State Medical Society. The Publication Committee and C. J. Tupper, M.D., Scientific Editor, were successful in improving further the quality of the scientific articles. For the first time, abstracts of articles also were printed to help the busy reader; and greater use was made of photographs, charts and medical illustrations. Typographical design also added to the impact of the scientific section to avoid having it appear dull and flat. The articles were carefully selected each month to provide valuable information for the total membership regardless of medical specialty. In former years, one issue dealt with one specialty and the next issue with some other disease. The change has been well received by the physicians of Michigan. Many of the articles were reprinted, with permission, by other medical publications, by pharmaceutical houses, by medical textbook authors and others.

Medical Socio-Economics and Research

To insure maximum utilization of its staff resources, The Council broadened the scope of the Economic Department's activity to include full staff responsibility for all committees of the Society which are concerned with medical socio-economic aspects. These include the Committee on Medical Socio-Economics, Committee on Professional Insurance Plans, Relative Value Study Committee, Committee on Rehabilitation, Committee on Uniform Fee Schedule for Governmental Welfare Agencies, Medicare Committee, Committee on Retirement Plans, Committee on Evaluation of Prepaid Medical Services, Committee to Study Establishment of MSMS Service Corporation.

Details of the activities of these committees will be found in their individual annual reports. Following are some highlights:

Uniform Fee Schedule for Governmental Welfare Agencies. The Council, upon the recommendation of the Uniform Fee Schedule Committee, approved the Michigan Relative Value Scale as the basis for a fee schedule for negotiation with governmental agencies, with a conversion factor related to current and customary fees. For the 1964 fee schedule, The Council established a $5 conversion factor and in addition authorized the Council Chairman to appoint, with the approval of The Council, a committee to determine at appropriate intervals what conversion factor represents current and customary fees.

New Business Overhead Insurance Program. The Council approved the Committee on Professional Insurance Program's recommendation of new Business Overhead Insurance Program for MSMS members. This program was announced to MSMS members by a special mailing in early June.

High-Level Accident Insurance Program. The new program of high level accident insurance as developed by the Committee on Professional Insurance Plans, approved by The Council, was announced to MSMS members by a special mailing in November, 1964.

Revised Medicare Fee Schedule. The Council approved the recommendation of the Medicare Committee that a recommendation be made to the Veterans Administration in Washington that the Michigan Relative Value Scale be adopted with a $5.00 conversion factor, as a new Medicare schedule covering dependents of members of the armed forces.

Rehabilitation Directory. Upon the recommendation of the Rehabilitation Committee, The Council approved the duplication and distribution to Michigan physicians of a new Directory of Michigan Medical Facilities for the Physically Impaired. This Directory was based on the results of a survey conducted by the Committee through component medical societies.

Revised Michigan Relative Value Study. As directed by the House of Delegates and The Council, the RVS Committee completed its assignment of reviewing the entire 1961 Michigan Relative Value Scale for the purpose of correcting alleged inequities. The Committee held lengthy conferences with representatives of major medical specialty organizations.

In July, The Council received the report of the Relative Value Study Committee and took the following actions:

Adopted the RVS Committee's recommendation that the new RVS be supplied to all those representatives of major specialty groups and the Michigan Branch of the American Academy of General Practice who conferred with the Committee over the past year.

Instructed that the RVS report be included in the Delegates Handbook to be distributed in advance of the 1965 meeting of the House.

Instructed that the title page of each copy of the study be marked in red: "This copy submitted for information and review only. It has not been acted upon by the House of Delegates and is not official."

Approved the RVS Committee's recommendation that "in compliance with the instructions of the House of Delegates, copies of this new RVS be sent to Michigan Medical Service for the purpose of monetary interpretation only, with the request that Michigan Medical Service report its written interpretation to the Speaker in advance of the House of Delegates meeting so that the report may be referred to the appropriate reference committe for advance study."

Approved the 1965 Relative Value Study with special commendation to the Committee.

(See Annual Report of Relative Value Study Committee.)

Survey of Professional Liability Insurance. A comprehensive survey of professional liability insurance coverage of MSMS members was conducted. (See Part III.)

Profile of Michigan Doctors of Medicine. A tabulation of professional and socio-economic characteristics of all Michigan doctors of medicine on a county-by-county basis was completed.

PART II

Annual Reports of Committees

Annual Reports from the following committees have been reviewed by The Council:

Committees of The Council

- Alcoholism & Drug Addiction
- Courses on Medical Economics & Ethics
- Education Liaison
- Establishment of MSMS Service Corporation
- Medicare
- Nursing
- Rehabilitation
- Relative Value Study
- Retirement Plan
- Uniform Fee Schedule for Governmental Welfare Agencies
- Veterans Affairs
- Liaison with Michigan Crippled Children Commission
- Liaison with State Board of Registration in Medicine

MSMS Committees

- Advisory to Michigan State Medical Assistants Society
- Diabetes
- Ethics
- Highway Accident Prevention
- Maternal Health
- Mediation
- Postgraduate Medical Education

The Annual Reports of the following committees, in the Handbook for Delegates, will not be considered by The Council until its September 18 meeting. If there are any comments or recommendations The Council wishes to make regarding these reports, they will be transmitted to the House in the verbal report of Council Chairman Hiscock.

Council Committees

Awards
Medical Aspects of Organized Athletics
Evaluation of Prepaid Medical Services
Liaison with State Pharmaceutical Association
Liaison with State Executive Office
Disaster Medical Care
Hospital Relations
Workmen's Compensation
Permanent Conference (MSMS representatives to)
Medicine & Religion
Liaison with Residents, Interns, Students
International Health
Liaison with State Bar of Michigan
Beamont Memorial

MSMS Committees

Public Relations
Medical Socio-Economics
Professional Insurance Plans
Judicial Commission
Legal Affairs
Mental Health
Public Health
Aging
Rural Medical Service
Blood Banks
Cardiac Disease
Child Welfare
Iodized Salt
Respiratory Diseases
Occupational Health
Scientific Radio & Television
Cancer Control
Medicine & Osteopathy

PART III

Matters Referred to the Council by the 1964 House of Delegates

Resolution 4 urged that The Council disseminate information regarding the advantages of medical practice in smaller towns in Michigan to the wives of senior medical students, residents and interns, through the Woman's Auxiliary to the Student American Medical Association and that this be done at the county as well as the state level. It was urged that formal liaison committees be formed between component medical societies and local SAMA chapters and between the auxiliaries of these two groups.

The Council requested the Michigan Health Council, because of its close liaison with SAMA chapters, to incorporate this suggestion of the House of Delegates in its program of liaison with SAMA Chapters and Auxiliaries in Michigan.

The Michigan Health Council has activated a publicity campaign in Student AMA publications concerning the advantages of practice in rural areas and this subject has become a component part of the Health Council's liaison activities with SAMA groups. The possibility of displaying an exhibit on this subject at the SAMA national meeting is being seriously considered.

Resolution 5 requested the Finance Committee of The Council, which had been studying the question of remuneration to officers of MSMS, to enlarge its study to include Councilors, and Delegates to the AMA. After considerable study by the Finance Committee and The Council, The Council adopted the following recommendation on this subject: "(1) That MSMS not remunerate AMA Delegates beyond expenses; (2) that MSMS not remunerate Councilors beyond expenses, and (3) that remuneration of component medical society officers be left to the discretion of the component medical societies."

(See Council recommendation in Part IV of this report.)

Resolution 7 requested that the Legal Affairs Committee be directed to initiate bills to improve the Michigan Medical Aid to the Aged Act. Toward this end, the MSMS Committee on Aging, the Michigan Commission on Aging and the Michigan Health Council were to be asked for suggestions. Also, all component medical societies were to be encouraged to more fully implement the MAA Program in Michigan. The Council referred this resolution to the Legal Affairs Committee which requested and received suggestions for improvement in the Act from the above-mentioned groups, and a bill was introduced in the Michigan Legislature which incorporated these suggestions. The bill was not adopted during the 1965 Legislative Session but possibly may be adopted by the next Session. (For further details, see Annual Report of the Legal Affairs Committee.)

A substitute resolution for Resolutions 10 and 17 directed that a special committee composed of "equitable" representation of (1) private practitioners and (2) representatives of the public health services be directed to develop a program for coordinating public health services (those dealing with community health problems) and personal health services (those involving specific diagnosis and treatment of the individual). Such a committee has been appointed but has not yet submitted its report.

Resolution 13 authorized appointment of a Committee on the Medical Aspects of Organized Athletics and requested component medical societies to urge their members to assist in the provision of medical services for "organized athletic programs." This Committee was appointed by Council Chairman Hiscock. A copy of the resolution was also sent to component societies of MSMS for information.

Resolution 16 instructed The Council to continue its study of a plan of financial assistance to needy physicians and their dependents and to report such a plan to the 1965 meeting of the House of Delegates. After considerable study by the Finance Committee and The Council, the following recommendation on this subject was adopted by The Council:

"(1) There is apparently no great number of physicians in Michigan who require aid, based on previous MSMS committee surveys; (2) However, some state fund should be instituted to meet the need that does exist, financed through an increase in dues; (3) Such a state fund should be administered on a matching basis with component medical societies."

(See Council recommendation in Part IV of this report.)

Resolution 19 called for a federal subsidy program to aid in the purchase of health insurance for the aging, and was to be forwarded to the AMA "for action."

The Council submitted this resolution to the MSMS Delegation to AMA for implementation, and the Delegation introduced a resolution to this effect at the December, 1964, Clinical Session of AMA. The AMA House of Delegates took no action on the Michigan resolution.

Resolution 22 called for the appointment of a Committee on Evaluation of Prepaid Medical Services, by January 1, 1965, as a fact-finding group without punitive powers, to evaluate utilization of such services. The resolution instructed that sources of information submitted to the Committee be *not* identified as to physician or patient. This Committee was appointed by Council Chairman Hiscock and has been working on development of plans for committee procedures.

(See Annual Report of Committee on Evaluation of Prepaid Medical Services.)

Resolution 25 opposed a proposed Rule 311.2 (2) of the General Court Rules of Michigan which would waive the patient-physician privilege upon commencement of a personal injury suit, and instructed that the vigorous opposition of MSMS to this proposed rule be made known to the State Bar of Michigan.

The Council referred this matter to the MSMS Liaison Committee with the State Bar. This committee ascertained that a Committee of the State Bar has recommended the proposed rule to the State Bar Commissioners. No action will be taken by the Commission until October or later. The MSMS Committee has formally transmitted MSMS and House of Delegates objection to the proposed Rule 311.2 (2).

(See Annual Report of Liaison Committee with State Bar of Michigan.)

Resolution 29 called for an official MSMS recommendation that the State Mental Health Department be a separate principal department of state government and, if necessary, vested with certain mental health responsibilities now assigned to other agencies. This resolution was referred to The Council "without prejudice" for any appropriate action.

The Council referred the resolution to the Legal Affairs Committee requesting that it be considered with a representative of the Mental Health Committee. The Legal Affairs Committee approved this position and it was subsequently transmitted to Governor Romney for his information.

Resolution 31 directed that an appropriate committee of MSMS establish standards and procedures for classification and licensure of medical facilities for the care of subacute illnesses.

The Council referred this matter to the MSMS Hospital Relations Committee. Tentative criteria for the classification of "subacute facilities"—i.e., nursing homes—were recommended by the Hospital Relations Committee and approved in principle by The Council at its June 16, 1965 meeting.

(See Annual Report of Hospital Relations Committee.)

Resolutions 32 and 39 both having to do with malpractice insurance coverage were referred to The Council.

Resolution 32 directed The Council to investigate and document allegations that some insurance agencies will not renew malpractice coverage unless the physician takes a "package deal" and, when appropriate, bring the matter to the attention of the Michigan State Insurance Commissioner.

The Council referred this resolution to the Finance Committee for implementation. A questionnaire was developed and mailed to all MSMS members to ascertain the extent of this problem. A report of survey results and their interpretation follows Part III of this Annual Report.

Resolution 39 directed that an appropriate committee investigate immediately the problem of malpractice insurance in Michigan, to include (1) availability of insurance from commercial carriers; (2) premium rates; (3) frequency of malpractice and suits, and (4) feasibility and desirability of establishment of a malpractice insurance company by MSMS. The resolution also directed that the Michigan Delegation to AMA be requested to initiate a similar study of malpractice insurance.

This resolution was referred to the Professional Insurance Plans Committee. Questions regarding the availability of malpractice insurance, premium rates, etc., were incorporated in the survey mentioned above. This information and the advisability of MSMS setting up its own insurance company are discussed in the Annual Report of the Committee on Professional Insurance Plans.

The Michigan Delegates to AMA introduced a resolution at the December, 1964, Clinical Session of AMA to initiate a similar AMA study, but the resolution was not adopted because "it was felt that these medical-legal problems can be best handled on the state level, utilizing to the fullest extent possible the wealth of information available from AMA."

Resolution 43 supporting the MSU School of Human Medicine was transmitted by letter to the Executive Office at Michigan State University and to appropriate committees of the Michigan Legislature.

Definition of Role of Public Health Departments. In reviewing the 1964 Annual Report of the Ad Hoc Committee to Study AMA Concept of Public Health, the reference committee recommended that MSMS develop a precise definition of the proper role of public health departments. The Council requested the Public Health Committee to develop this definition. In July, the Committee submitted its proposed definition to The Council for review. The Committee's recommended definition was disapproved by The Council because it felt that the definition lacked the requested and desirable preciseness.

MSMS Professional Liability Insurance Survey—1965

1. *Purpose.* The survey had two objectives:
   a. To ascertain what difficulties, if any, MSMS members had experienced in either obtaining or continuing professional liability insurance coverage.
   b. To provide additional data to the MSMS Committee on Professional Insurance Plans. This committee has under active study the feasibility and desirability of MSMS establishing its own professional liability insurance company.
2. *Survey Questionnaire.* Apart from asking for basic data, the survey questionnaire was structured to afford an opportunity for MSMS members to make known in detail any difficulty they might have had with their professional liability insurance coverage.
3. *Summary.*
   a. Number of questionnaires sent out — 7,400
   (A questionnaire was sent to each MSMS member)
   b. Number of questionnaires returned — 2,503 (34% of total) (This is an excellent participation as most surveys of this type have about a 10% return.)
   Breakdown of returns by Specialty Class (for insurance purposes).

Class I	Cardiovascular Disease, Allergy, Pediatrics, Pathology, General Practice (No Surgery or Anesthesia), Psychiatry (No Shock Therapy), Radiology, Dermatology (No X-ray Therapy).	946
Class II	Psychiatry (including EST), General Practice (Normal Delivery or Assisting in Surgery).	210
Class III	General Practice (Doing Surgery, or Anesthesia), Proctology, Ear-Nose-Throat, Ophthalmology.	596
Class IV	Surgery, Urology, Orthopedic Surgery, Plastic Surgery, Thoracic Surgery, Neurological Surgery, Cardiovascular Surgery, Vascular Surgery, Anesthesiology, Obstetrics-Gynecology.	751
		2,503

   c. Number of returns indicating professional liability insurance coverage —2,470 (99% of total returns)
   Of these 2,470, 126 indicated difficulty in obtaining or continuing professional liability coverage for the following reasons:
      1. Reached a certain age 10
      (Of these 10 returns, 6 indicated over age 65 and 2 indicated over age 60. The remaining 2 did not indicate a specific age.)
      2. Agent insisted on selling other insurance 61
      (Of these 61 returns, 22 specified one particular insurance carrier and/or the same agent of this particular carrier.* The remaining 39 did not elaborate.)
      3. Carrier discontinued the writing of professional liability insurance 11

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*We have been advised by MSMS Legal Counsel that this problem no longer exists.

4. Carrier would not write insurance because of medical history.	1
5. Carrier would not write insurance because of medical specialty. (Of these 3 returns, 2 indicated radiology and the other did not specify.)	3
6. Carrier would not write insurance because of previous or pending claim.	9
7. Carrier offered no explanation as to why he would not write insurance.	5
8. All other.	6
9. No explanation stated by physician on his return.	20
	126

d. Number of returns indicating *no* professional liability coverage — 33 (1% of total returns)

(Of these 33 returns, 4 indicated that they were refused because they had reached a certain age, 1 had a disqualifying medical history, 6 indicated employment by either private industry or a state or county agency, 2 were retired, 1 was a resident, 1 indicated it was too expensive, and 1 indicated ethnic discrimination. The remaining 17 did not elaborate.)

4. *Conclusion.* Professional liability insurance is generally available to all MSMS members. However, certain problem areas have materialized as outlined in parts c and d above. It would appear advisable that each MSMS member should review his individual situation with his insurance carrier now, so that he will have a clear understanding of his carrier's underwriting requirements and restrictions.

PART IV

Recommendations of The Council

Recommendation One

The Council recommends adoption by the House of Delegates of the following policy:

"That all fees for physicians' services and medicines be kept entirely separate from day rates for nursing home care, since the establishment of an all-inclusive rate might lead to poor and inadequate medical care and tend to separate the patient from his family physician."

Recommendation Two

The Council recommends "(1) That MSMS not remunerate AMA Delegates beyond expenses; (2) that MSMS not remunerate Councilors beyond expenses, and (3) that remuneration of component medical society officers be left to the discretion of the component medical societies."

Recommendation Three

The Council recommends, with regard to possible financial assistance to needy physicians and their dependents, that although there is apparently no great number of physicians in Michigan who require aid, based on previous MSMS committee surveys, some state fund should be instituted to meet the need that does exist, financed through an increase in dues, and such a state fund should be administered on a matching basis with component medical societies.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander Blain, M.D., Chairman, did not consider Item 1 of the Annual Report dealing with the Judicial Commission, and Item 40, part 1 under Medical Social Economics and Research dealing with revised fee schedule, as these items were referred by the Speakers to other reference committees.

The Reference Committee considered the individual items of the Annual Report of The Council, including reports of Council committees and the supplemental report of The Council Chairman and Finance Chairman, and approved the entire report with the following exceptions or amendments:

"Item 15, Part I, Implementation of Medicare Program. Starting with line 3, it was recommended that any contract bargaining should be done by medical organizations. This Reference Committee recommends to The Council that it use all available resources and the expert advice of the private carriers and Blue Cross-Blue Shield.

"Item 35, Part 1: The Reference Committee approves The Council's interim action on fee schedules for governmental agencies as embodied in paragraphs 34 and 37 to be used prior to implementation of Public Law 89-97. This is essentially the application of a $5 conversion factor to the 1961 Michigan Relative Value Scale."

"Under matters referred to The Council, Resolution 5, part 3, paragraph 2: The Reference Committee accepts the original recommendation of The Council, and it further recommends that The Council consider the possible future necessity for remuneration to the officers with the increasing time burden placed on them after implementation of Public Law 89-97.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE REPORTS

14. Annual Reports of Council Committees

COMMITTEE ON ALCOHOLISM AND DRUG ADDICTION

R. C. Bates, M.D., *Chairman*

Three meetings have been held:

A meeting with Dr. E. C. Swanson to explore methods of helping addicted physicians.

At Ypsilanti State Hospital to explore treatment facilities for the increasing numbers of alcoholics treated in state hospitals.

A meeting with Secretary of State James Hare to discuss the problems of drinking drivers.

The past year has seen new facilities for the treatment of alcoholics at the Battle Creek Health Center and St. Luke's Hospital in Saginaw. Lectures on alcoholism have been given throughout the upper peninsula under the Postgraduate Program of MSMS at the suggestion of the State Board of Alcoholism. Last summer, two doctors were given scholarships to attend the Rutgers School of Alcohol Studies by the Michigan Foundation for Medical and Health Education, and two more will be sponsored this summer.

Thorough reviews of all legislation concerning alcoholism, drunken driving and the State Board of Alcoholism were made and recommended actions forwarded to The Council.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON AWARDS

Wm. A. Hyland, M.D., *Chairman*

The Centennial observance of MSMS quite naturally changed the usual annual awards patterns. MSMS will take advantage of the Centennial Session to show its deep appreciation to many firms, organizations and individuals.

Two other annual award activities were continued by the Committee—MSMS award to Michigan physicians who serve as presidents of national medical organizations, and MSMS 50-year awards to physicians who have practiced 50 years.

The Committee report follows in three parts:

I. Centennial Session Awards

The Awards Committee met May 10, 1965, for a thorough discussion of the awards ramifications of the 1965 Centennial Session. The Committee recommendations were approved May 12, 1965, by The Council to designate classifications for special Centennial Session Awards and the physical nature of the awards and mementoes.

The Council approved the Committee plans to present the following "Special Awards and Recognition appropriate during the Centennial Session":

1. Recognition to each seated delegate of Centennial Session of the MSMS House of Delegates.
2. Recognition to members of The MSMS Council and the Officers.
3. Recognition of the 18 living past presidents of MSMS.
4. Recognition of each president of a national medical or ancillary organization who attends MSMS Centennial Session.
5. Recognition of each state medical society president who attends MSMS Centennial Session.
6. Recognition of other specially-invited leaders of medical and ancillary organizations.

Recognizing that the various days of the Centennial Session provided an ideal opportunity for special awards, The Council approved the final Committee recommendations:

A. On Medicine and Business, Industry and Communications Day, Monday, September 20:

(1) Citations to one divisional representative of Business, Industry and Communications for their services to medicine and the state.

Business: S. S. Kresge Company
Industry: W. K. Kellogg Company
Communications: WJBK, WJBK-TV, Detroit

(2) Recognition of another 20 representatives of the fields of Business, Industry and Communications for their services.

Business: Campbell-Ewald Advertising Company
Medical Exhibitors Association
Michigan Chapter, Health Insurance Council
J. L. Hudson Company

Industry: Chrysler Corporation
Dow Chemical Company
Ford Motor Company
General Motors Corporation
Gerber Products Company
Gerity-Michigan Corporation
Parke-Davis & Company
Pharmaceutical Manufacturers Association
Smith Kline & French Laboratories
The Upjohn Company

Communications: Booth Newspapers
Detroit Free Press
Detroit News
Federated Publications
Michigan Association of TV and Broadcasters
Michigan Chapter, American Medical Writers Association
WJIM, Lansing

B. On Medical Organization Day, Tuesday, September 21:

(1) MSMS Award to Michigan Medical Service

(2) MSMS Award to Michigan Hospital Service

(3) Presentation to each county medical society of a reproduction of their original charter before the House of Delegates. (The new charters will be issued throughout the year at the county medical society meetings by MSMS.)

C. On Medicine and Voluntary Health Day, Thursday, September 23:

(1) Appreciation awards to the 100 voluntary health organizations in the Michigan Health Council.

(2) Appreciation award to the Michigan Health Council.

(3) Special award to Marshall Fredericks, AIA, Humanitarian.

D. On Medicine and Government Day, Friday, September 24:

(1) Citations to the three Michigan M.D.s who were elected to state offices.

(2) Citation to the one living former M.D. Michigan legislator.

(3) Recognition of Michigan M.D.s serving on appointed state bodies.

(4) Recognition of Michigan M.D.s elected to less than state office. (Listed only in program.)

(5) Citation to one or two outstanding state or national public servants for interest in field of health.

II. Awards to National Presidents

As in the past, the presentations by MSMS to these distinguished medical leaders from Michigan highlighted the annual Officers Conference (formerly known as the County Secretaries-Public Relations Seminar). Recommended by the Committee and approved by The Council, these awards were given to

1. Brock E. Brush, M.D., Detroit, President of the American Geriatrics Society;

2. Harold F. Falls, M.D., Ann Arbor, President of the National Medical Foundation for Eye Care;

3. D. Emerick Szilagyi, M.D., Detroit, President of the International Cardiovascular Society;

4. H. A. Towsley, M.D., Ann Arbor, President of the American Academy of Pediatrics.

III. 50-Year Awards

The 1965 House of Delegates will recognize the following physicians as having served the science of medicine for 50 years or more:

Clinton County: Charles T. Foo, M.D.

Crawford County: Stanley Stealy, M.D.

Genesee County: George J. Curry, M.D., and John J. Kurtz, M.D.

Grand Traverse County: Russell R. Huston, M.D.

Ingham County: O. M. Randall, M.D.

Jackson County: R. M. Cooley, M.D., C. E. DeMay, M.D., and Frank Pray, M.D.

Menominee County: W. S. Jones, M.D.

Muskegon County: Marie Keilin, M.D.

Washtenaw County: A. C. Furstenberg, M.D.

Wayne County: Van D. Barnes, M.D.; Edward T. H. Best, M.D.; James G. Carr, M.D.; Harold E. Clark, M.D.; Thomas H. Crews, M.D.; J. J. Drake, M.D.; Robert Greenidge, M.D.; John W. Hansen, M.D.; Harry E. Lee, M.D.; Daniel J. Leithauser, M.D.; William W. MacGregor, M.D.; Elwood A. Sharp, M.D.; Max Silverman, M.D.; Fred M. Slaughter, M.D.; Hugh A. Sullivan, M.D.; Jacob M. Sutherland, M.D.

THE REFERENCE COMMITTEE on Reports of The Council Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

BEAUMONT MEMORIAL COMMITTEE

R. J. Mason, M.D., *Chairman*

The dynamic year 1965, our Centennial Year, has also brought about the transfer of supervision of that stellar tourist attraction—"The MSMS Beaumont Memorial Building on Mackinac Island," from the Beaumont Foundation to a special MSMS Council committee. The memorial building is in a good state of repair, the personal furniture belonging to Doctor William Beaumont is well preserved and the four special dioramas depicting episodes in the medical experiences of Doctor Beaumont are well displayed. The dramatic "Beaumont Story" is well narrated every fifteen minutes by competent Park Commission personnel to an enthusiastic tourist throng. All members of MSMS can take justifiable pride in their Memorial to a great Michigan physician, Doctor William Beaumont.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON COURSES ON MEDICAL ECONOMICS AND ETHICS

C. Howard Ross, M.D., *Chairman*

The current year in Ann Arbor has been most successful. Through the instrumentation of the energetic President of the University of Michigan Senior Medical Class, Mr. Arthur Fleming, the hour has been changed to 12:30 p.m. The students could thus bring their lunch in an informal gathering. The increase in attendance has been remarkable. Lectures were terminated April 14, 1965.

At Wayne State University College of Medicine correspondence has been conducted with Alexander Walt, M.D., Assistant Dean. Doctor Walt has promised consultations with the President of the Student Council, the President of the Senior Medical Class and the Education Committee of the Wayne County Medical Society. He will offer us later a schedule wherein our Committee may institute lectures.

SCHEDULE OF LECTURES BEFORE THE UNIVERSITY OF MICHIGAN SENIOR MEDICAL CLASS

Development of a Fee Schedule, C. Howard Ross, M.D. (July 1, 1964). Here details of unit values are applied from small endeavors to vast surgical adventures.

The Doctor in Court, Judge James R. Breakey, Jr. (July 15, 1964). The doctor enters the Court Room and becomes the "explaining witness" before the Jury.

History of Ethics, C. Howard Ross, M.D. (July 22, 1964). The Golden Rule begins with Hippocrates and extends on down to today's dedicated profession.

The Morality of Specialty Procedures, Medical and Surgical, Richard Craft, M.D. (August 12, 1964). We enjoyed a most lively analysis of medical and surgical judgment, applied to diagnosis, operations and extreme procedures.

The Sociological Aspects of Ethics, Charles J. Tupper, M.D., Associate Dean; Panel: George Morley, M.D., Professor of Obstetrics-Gynecology, C. Howard Ross, M.D. (August 19, 1964)

(a) *Race Explosion*

(b) *Family Planning*

(c) *Rhythm Technics Versus Diaphragm and Other Modalities*

(d) *Therapeutic Abortion, Criminal Abortion*

(e) *Artificial Insemination*

(f) *Has the Decrease in the Incidence of Therapeutic Abortion Found its Origin in Science or Morality?*

(g) *Catholic Hospital Codes, General Hospital Codes*

(h) *Surgical Attacks on Organs of Procreation Male and Female, Sterilization*

(i) *Removal of Diseased Organs Containing Embryo*

(j) *Should a Catholic Resident in a General Hospital Dismiss Himself From an Operation that Specifically Does Not Meet His Code?*

(k) *Doctor and Nurse Relationships in Patient Responsibility*

(l) *Right to Die*

(m) *Terminal Care*

Here was a most vital exchange of wits. Thirty-eight questions and suggestions bounced from the audience.

Hospital and Internship Day, W. N. Hubbard, M.D., Dean, Harry A. Towsley, M.D. (August 26, 1964). Hospitals of Michigan sent their representatives, with opportunities for student interviews at designated booths.

Granny's Herbs and the Witch Doctor, C. Howard Ross, M.D. (September 9, 1964). "Nether Medicine" makes the grade once in a lifetime; and there were many lifetimes in the past.

A Doctor Walks Among Many Religions, Winslow G. Fox, M.D. (September 16, 1964). How does the physician behave with orthodoxy and heterodoxy; and which is which? (Students attended Michigan State Medical Society Annual Session, September 21-September 23, 1964).

Duo Versus Singleton Practice, Howard Williams, M.D., and Jack Bush, M.D. (October 14, 1964). The specialty for 1964 was obstetrics. Last year the team of generalists performed, but the principles of activity remained the same.

Continuing Medical Education, Wm. N. Hubbard, M.D. Dean (October 28, 1964). Medical education continues until the last gasp.

Economics and Ethics of Hospital Administration, Henry Morris, Associate Administrator, St. Joseph Mercy Hospital and Roger Nelson, M.D., Associate Director, University Hospital (November 11, 1964). How do men, materials, dollars, services and management get going?

The Doctor's Accounting System, C. Howard Ross, M.D. (November 18, 1964). The lifting of the telephone receiver is advanced to schedule C of the income tax.

An Ethical Approach to Geriatrics, C. Howard Ross, M.D. (December 9, 1964). The students are given a painless approach to the care of the elderly, with principles of terminal administration.

A Medical Look Ahead, Charles J. Tupper, M.D., Associate Dean (January 13, 1965). Medical history is revealed in reverse.

Medical Manpower, A. C. Furstenberg, M.D., Dean Emeritus (January 27, 1965). Michigan and the United States are compared. The water wonderland beckons.

Orientation with the Specialties, a General Practice Panel, Moderator: Fred C. Brace, M.D., President MAGP (February 10, 1965).

(a) *General Practice and the Specialties*—Lyle Korum, M.D.

(b) *Consultation Techniques*—Clare C. Huggett, M.D.

(c) *Art of Practice*—Francis P. Roades, M.D.

(d) *General Practice, the Keystone*—Russell Fenton, M.D.

(e) *Medical Organization*—E. Clarkson Long, M.D.

(f) *Summary*—C. Howard Ross, M.D.

Medical Communications and Public Relations, Hugh Brenneman, Executive Director, MSMS and Wallace Teed, M.D., (February 24, 1965). The Doctor lives with the public, his patients, his family and himself. The Cadillac car and the snippy office secretary are discussed, among many challenging subjects.

Medical Placement in Michigan, Mr. John Doherty and Robert Rice, M.D., of the Michigan Health Council (March 10, 1965). A vacuum in a community finds an instrumentality for securing a physician.

The Surgeon and His Fee, Charles G. Child, M.D., Chairman, Dept. of Surgery, UMMS (March 17, 1965). Are there gradations? How do we meet them?

Professional Management Versus Rugged Individualism, Douglas Wilson and Associates (March 23, 1965). The modern physician, a professional in services and business, may require assistance from both ends.

Assembly, Junior Medical Class, C. Howard Ross, M.D. (April 14, 1965). An advance summary of the coming year's activities is offered in an impromptu and inspirational form.

We have not forgotten the following subjects, which did not quite make the grade this year:

(a) *Academic Medicine*—Pros and Cons

(b) *A Doctor's Philosophy*

(c) *Orientation Committee, Washtenaw County Medical Society*
(d) *The Doctor and His Home Community*
(e) *The Veterans' Problem*
(f) *Coordinating Home Care Program*
(g) *An Analysis of Convalescent Homes*
(h) *How to Land in Court in Ten Easy Lessons*

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON DISASTER MEDICAL CARE

G. L. Otis, M.D., *Chairman*

The Committee on Disaster Medical Care met quarterly during the past year, and has been actively striving for continued improvement of techniques and responsibilities for doctors of medicine and allied groups during major disasters within the state.

The following are a few of the many activities that were discussed and on which some recommendation to The Council was made:

A policy position of the Michigan State Medical Society with regard to state-wide major disasters and the pre-planning of methods and procedures by which it is hoped to minimize serious injury and provide the best in emergency care for casualties.

The Committee chairman participated in the AMA Regional Conference on Disaster Medical Care held at Louisville, Kentucky in July, 1964.

The members of the Committee were briefed by the Macomb County Health Officer re the Anchor Bay Disaster which indicated certain trends that occur in major disasters which make it necessary for better pre-planning, for health care.

The Committee studied a proposal from Mr. William Powell, Regional Civil Defense Coordinator for the Michigan State Police regarding a pilot project proposed in the Bay City area for an exercise in disaster care and offered assistance with this project.

The Committee also met with Mr. Donald Hughes, Civil Defense Coordinator for the Michigan Public Health Service Commission and participated in a meeting with representatives of transportation, government agencies and medicine with specific emphasis on Nuclear Accident Potentials. This meeting was held November 18, 1964 and was followed by a recommendation from the Committee to The Council, MSMS of a six-point statement of principles with regard to transportation in case of a nuclear accident or civil emergency.

In March 1965 the Committee chairman met with Mr. Richard Hines of the Michigan Hospital Association and Mrs. Joan Guy of the Michigan Nursing Association and explored the possibility of developing a uniform Medical-Hospital administrative plan for State, Regional and County levels that might allow all three professions to better prepare for activities in case of major disaster.

The Committee recommended to The Council that a one-day symposium on Nuclear Disaster Medicine be held at Ann Arbor co-sponsored by the Michigan State Medical Society, this conference to be by invitation of those physicians in Michigan specifically interested in or licensed by the Atomic Energy Commission in the field of Nuclear Medicine. The Council felt that this proposal which involved the expenditure of some funds was not completely organized at this time and withheld approval until added data and plans could be developed, and budgetary appropriations made.

MSMS Disaster Care Policy Statement

1. The Disaster Medical Care Committee, MSMS stands for and recommends a strong, active individual hospital disaster plan for all hospitals within the State of Michigan.

2. The Disaster Medical Care Committee, MSMS stands for and recommends a strong county coordinated plan for health services to be able to attain the best quality health care in each county for disaster victims.

3. The Disaster Medical Care Committee, MSMS, stands for and recommends a strong multiple county coordinated plan (often called region or district control) for health services to be able to attain the best quality health care within the several counties that make up the various regions of the state.

4. The Disaster Medical Care Committee, MSMS, stands for and recommends a strong state advisory committee, which will aid the needs of the collective regions of our state, and will take the responsibility of securing, through established channels, supplies, and personnel that may be needed from (a) other regions of the State or (b) from other states.

5. The Disaster Medical Care Committee, MSMS, recommends that these aims be sought with the cooperative efforts of the Michigan Hospital Association and the Michigan State Nurses Association and other health disciplines for purposes of teamwork necessary to attain the best quality of health care for our citizens, this cooperation being necessary whether the devastation be that of a natural disaster, or of enemy action. The Committee further feels that this is a primary responsibility of the MSMS, the Michigan Hospital Association, and the Michigan State Nurses Association, to work as a team and to be ready to work independently if necessary, or to work within the framework of the Civil Defense Laws of the State of Michigan, whichever is applicable at the time of disaster.

MSMS Six-Point Statement of Principles

1. Transportation, like all people in the State of Michigan, should follow specific instructional information. It is urgent that people, in whatever category, seek shelter and use self help to save lives during hazardous radiation.

2. R.A.D.E.F., through monitors under its control, should have the final say as to when it is considered safe for any group to come out of shelter, whether it be the transportation industry, medical doctors, etc.

3. Committee on Disaster Medical Care is opposed to deliberate exposure to any degree for any category of personnel. Any deliberate exposure, pre-planned should be cleared by mature top level medical decision. Such exposure should be done only to the extent that by deliberately doing so a greater number of lives may be saved by the sacrificing of a few. Before any decision of such serious implications is done, clearance through the health services should be obtained and physicians are available prior to any movement of personnel or material. Further, that this hazardous exposure, deliberately done, should not take medically skilled people away from treating and aiding the greater number for the questionable benefit of a few.

4. The Committee on Disaster Medical Care, Michigan State Medical Society, will work in collaboration with the State Health Department, who by law is responsible for planning and execution of medical civil defense.

5. The Committee on Disaster Medical Care of the Michigan State Medical Society, being a committee of The Council, is not in a position to invite industry to designate a member to this committee. However, this committee, with its authorized advisors, can invite transportation at any time to discuss with us problems of mutual interest.

6. We congratulate Mr. Donald Hughes in the Michigan Public Service and the Grand Trunk Western Railroad and all representatives for initiating this meeting and discussion, fully realizing that plans and discussions are vital before any training could possibly be done.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

EDUCATION LIAISON COMMITTEE

Don Marshall, M.D., *Chairman*

The Committee met on June 2, 1965, at Ann Arbor, with the three deans of Michigan medical schools present as guest advisors.

A thorough discussion was held on the education of medical students in Michigan, the output and needs of the two medical schools, and the possibility of and requirements for an increase in graduates.

The Committee recommended that MSMS urge greater financial support for higher education, especially health-related, on existing Michigan universities; and that MSMS support legislation now pending in Congress to accomplish this. Both recommendations were approved by The Council on June 16.

The Committee will meet again on September 15.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON EVALUATION OF PREPAID MEDICAL SERVICES

B. C. Payne, M.D., *Chairman*

This Committee was formed in response to the 1964 House of Delegates Resolution No. 22.

In a series of meetings the Committee accepted Resolution No. 22 to encompass any and all prepaid medical services rendered in Michigan. It was agreed that any such evaluation should be one to continue year by year, should measure the appropriateness of hospital admissions, care within the hospital, standards of practice both within the hospital and certain outpatient procedures and length of stay.

It was observed that a previous comprehensive and definitive study of "Medical and Hospital Economics" prepared by the University of Michigan and published by the Hospital Research and Educational Trust of Chicago covered this area much more effectively than this committee could hope to do. It was therefore recommended that the procedures developed in this study be utilized and adapted to the needs of the medical staff and hospitals of Michigan.

To this end criteria for optimum medical care should be developed for diagnosis accounting for in excess of 50 per cent of discharges from hospitals, these criteria to include indications for hospital admission, hospital services for optimum care, the expected length of stay when possible, and discharge criteria. These criteria are to serve as guidelines for evaluation or audit committees in each hospital, or when this is not feasible because of the small number of staff in small hospitals, such a committee may function for several such hospitals (for instance in the three county area of the upper portion of the lower peninsula).

The cases are to be reviewed in retrospective (non-current) fashion for the purpose of identifying areas of ineffective hospital use or use of hospital facilities, inadequate services or excessive stay. The educational aspect of this local effort is paramount, requires complete cooperation and involvement by the medical staff and must not be punitive in nature. Reports are to be made to the hospital staff and/or involved departments and referred to the executive committee of the hospital for action.

Satisfactory evidence that functioning audit committees are present in all hospitals will be received by this or a similar Michigan State Medical Society committee.

Both Michigan Hospital Service and Michigan Medical Service have indicated an interest in the satisfactory functioning of such committees and offered both technical assistance and financial support. The nature of this cooperation needs further investigation before final recommendations are made.

It is the hope of this committee that successful petitions to the Joint Committee for Hospital Accreditation will give added impetus and acceptance to this particular form of evaluation of medical care within hospitals. Even without such a requirement by the Joint Commission, there is the strong likelihood that this form of evaluation of medical care in hospitals will satisfactorily meet the requirements of Section K in the pending "Medicare" Bill before Congress. It is desirable that a plan for utilization study be ready for implementation if, or when, such congressional action is taken.

At its meeting of June 16, 1965, The Council adopted the following substitute Recommendations of this Committee:

"SUBSTITUTE RECOMMENDATION ONE: That The Council request the Joint Commission on Accreditation of Hospitals to establish a requirement that all accredited hospitals have a functioning evaluation (utilization) committee which would evaluate the quality of medical care and effectiveness of hospital use in its area. These committees in Michigan should use criteria established by the Michigan State Medical Society, and these committees should *not* function as claims review committees. The reports of these utilization committees shall not be made available to insurance companies."

"SUBSTITUTE RECOMMENDATION TWO: That The Council recommend to each component medical society that it endeavor to have every hospital medical staff in its area establish an evaluation (utilization committee) which would evaluate the quality of medical care and effectiveness of use in its hospitals, using criteria based on diagnosis to be established by the Michigan State Medical Society. It is *not* the function of these committees to include claims review. It is further recommended that each component medical society, where appropriate, set up a similar committee to correlate and supervise the hospital committees and adjudicate disputes when they arise. The reports of these evaluation committees shall not be made available to insurance carriers."

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

HOSPITAL RELATIONS COMMITTEE

R. V. Taylor, M.D., *Chairman*

It is the responsibility of the MSMS Hospital Relations Committee to coordinate and combine medical and hospital interests in order to improve health care and to maintain minimum hospital cost through cooperative effort. In order to accomplish these aims the Committee regularly maintains liaison with the Michigan Hospital Association, Michigan Hospital Service, Michigan Medical Service, Michigan Department of Health, and all other appropriate private and governmental agencies.

The Committee has met on four occasions since the 1964 annual MSMS session. It has formulated recommendations to The Council, MSMS for transmittal to the Michigan Commission on Aging; studied MSMS participation in the newly formed Hospital Research and Educational Reserve of Michigan, Inc.; evaluated proposed Rules and Minimum Standards for Hospitals as developed by the Michigan Department of Health; reviewed a statement regarding Dependent Nursing Functions as developed by the MSMS Committee on Nursing prior to its dissemination to all MSMS members via *Michigan Medicine;* reviewed, for The MSMS Council, the publication "Physician-Hospital Relationships" developed by the American Medical Association; recommended action to The Council regarding procedure to be followed in cases of alleged arbitrary restrictions by hospitals against general practitioners or other non-specialists; through The Council, distributed to all members via *Michigan Medicine* the AMA Reference Committee Report on Insurance and Medical Service, and the Report of the AMA Committee on Medical Practices; and made an exhaustive study leading to recommendations regarding the classification of nursing homes.

On October 28, 1964, The MSMS Council, upon recommendation of the Committee, transmitted to the Michigan Commission on Aging statements of State Medical Society policy in the areas of: periodic health evaluations, medical fees for all age groups, multiple screening programs, medical conditions in older age groups, "preventive services" in relation to private medical practice, teaching of preventive medicine, county society committees on aging, training of ancillary health personnel, study of long-term care needs, liaison with other groups to study the relationship between nursing homes and hospitals, improvement of rehabilitation procedures, rehabilitation services in relation to the State Department of Health, homemaker and housekeeping services, coordinated home care programs, paid-up health insurance, information service regarding health resources, and separate state and county welfare administration. The full text of these several statements is incorporated in the minutes of the October 14, 1964 meeting of the Committee.

In December, the Committee recommended to The Council that MSMS officially participate in the Hospital Research and Educational Reserve of Michigan, Inc. and The Council approved the recommendation. As a result, MSMS is represented on the Health Facilities Planning Council of the Reserve.

Resolution No. 31, 1964 House of Delegates, was referred to the Committee for purposes of defining sub-acute medical facilities (nursing homes) and classifying same. In its subsequent study the Committee reviewed materials developed by the National Council for Accreditation of Nursing Homes, the American Medical Association, the American Hospital Association, Michigan Hospital Service, and the Michigan Department of Health. Meetings were held at which the Michigan Department of Health, The American Medical Association, Michigan Hospital Association, and Michigan Medical Service were represented. On May 5, the Committee reported to The MSMS Council submitting a definition of a "nursing home," a three-page preliminary draft of proposed requirements for classification of nursing homes as "comprehensive," "standard" or "basic," and a sixteen-point analysis of the requirements. The Committee's recommended criteria for nursing home classification was approved by The Council in principle and the Committee will continue to work closely with the Michigan Department of Health in the drafting of final rules and regulations for use by the State of Michigan in setting forth basic requirements for State certification.

The Committee has also continued to observe developments on the question of payment for anesthesiology services, which was covered in some depth in the 1963-1964 Annual Report of the Committee, and will carry this matter over into its 1965-1966 deliberations.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON INTERNATIONAL HEALTH

R. K. NIXON, M.D., *Chairman*

At its January, 1965 meeting, the MSMS Council approved a preliminary report submitted by the one-man Committee on International Health, which recommended, among other things, that the Medical Society recognize the importance of International Health by designating this as a permanent Committee, and by appointing additional members to serve on the Committee. Five additional members were subsequently appointed, and two meetings of the full Committee held.

1. The decision was made to set up a clearing house of information for Michigan physicians who wish to contribute their time and talents in any one of the numerous AMA-approved international health projects being operated in all parts of the world.

In order to implement this program, the Committee has developed a detailed questionnaire soliciting essential information from physicians who indicate interest in temporary medical service overseas. A covering letter approved by the Committee is to be attached to the questionnaire. As soon as Council approval of questionnaire and letter has been received, a mailing will be made on a one-time basis to all MSMS members, and to each new MSMS member, following receipt of his first year's dues.

2. Recommendation was made that the Chairman of The Council or the MSMS President dispatch a letter to the President of each County Medical Society, formally notifying him of the creation of the new MSMS Committee on International Health, and suggesting that in the next 12 month period, each County Medical Society devote one of its meetings to a program on International Health. Members of the Committee volunteered to participate in these programs.

3. A project of secondary emphasis, which was considered at length, is the establishment of a hospitality program designed to make the stay of visiting foreign physicians and foreign medical students more meaningful. In implementing this program, it was determined that the assistance of the MSMS Auxiliary would be sought.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH MICHIGAN CRIPPLED CHILDREN COMMISSION

A. C. STANDER, M.D., *Chairman*

Although no formal meetings have been held during the past year with members of the Crippled Children Commission, MSMS staff members have worked closely with the Commission's Director and staff in the preparation of legislation, and necessary supporting data, which is currently under consideration in the Michigan State Legislature for the purpose of increasing the fees paid to Michigan physicians under the Commission's programs.

(The Michigan Crippled Children Commission will meet with The Council at their annual breakfast meeting at Mackinac Island in July 1965).

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH THE MICHIGAN STATE PHARMACEUTICAL ASSOCIATION

R. V. DAUGHARTY, M.D., *Chairman*

The 1963 MSMS House of Delegates adopted Resolution No. 63 directing the MSMS Council to give consideration to the adoption of "guidelines through which county medical society liaison committees between Medicine and Pharmacy could most effectively function." This resolution was referred to the state-level liaison committee with the Michigan State Pharmaceutical Association, which prepared tentative inclusions in a "code of understanding" and certain additional recommendations for consideration by The Council.

The Council, after reviewing the Liaison Committee's recommendations, noted that the AMA House of Delegates, in 1963, had received an interpretive report regarding Section 7 of the Principles of Medical Ethics, rendered by the AMA Judicial Council. In the view of the MSMS Council, this interpretive report pertained to the purpose of Resolution No. 63, and constituted an adequate "guideline through which the liaison committees of the component societies can effectively function." The AMA Judicial Council said:

"Section 7 of the Principles of Medical Ethics provides: 'Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.' Under this language it cannot be considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of his patient.

"It is unethical for a physician to have financial interest in a drug repackaging company.

"It is unethical for a physician to own stock in a pharmaceutical company which he can control or does control while actively engaged in the practice of medicine.

"The Council calls to the attention of the House the following statement concerning the meaning of the words 'Drugs, remedies or appliances may be dispensed or supplied provided it is in the best interest of the patient' which was adopted by The Council on June 26, 1958.

"It is the opinion of the Judicial Council that this language was adopted to permit both the practicing physicians *and the local medical societies* to evaluate the many factual situations incident to prescribing and dispensing which are bound to arise in the practice of medicine. Under this language the doctor is permitted to exercise his own best judgment when caring for his patients. It is known that there will be situations where it is necessary or desirable for a physician to dispense or supply what he has prescribed. The Principles permit this to be done. On the other hand, this broad language provides a means by which *a component medical society can* inquire into the facts of a particular practice. The profession can thus act to prevent abuse of discretion and protect patients from exploitation. In essence this language means that a physician in the exercise of sound discretion may dispense 'in the best interest of his patient'; it does not authorize him to dispense solely for his convenience or for the purpose of supplementing his income."

No business in addition to the consideration of Resolution No. 63 of 1963 was referred to the Liaison Committee with the Michigan State Pharmaceutical Association during 1964-1965.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH RESIDENTS, INTERNS AND SENIOR MEDICAL STUDENTS

N. D. Henderson, M.D., *Chairman*

Over the last 12-month period, the Liaison Committee with Residents, Interns, and Senior Medical Students met on two occasions. Listed below are the highlights of these two meetings.

Because of the myriad of activities scheduled in conjunction with the MSMS Centennial Celebration, it was decided that the annual Resident-Intern-Senior Medical Student Conference, usually conducted at the time of the Annual Session, would be eliminated (for 1965 only). Recommendation was made that Tuesday of the Centennial Session be designated as a day on which Residents, Interns and Senior Medical Students would receive particular recognition.

An offer from a pharmaceutical firm to host an R-I-S reception during the Centennial Session was accepted. The Executive Director of SAMA and Warren R. Mullen, M.D., of Pentwater, Michigan, (first national president of SAMA) were invited to this reception as honor guests.

In response to a recommendation that medical students be invited to serve as non-voting members of the committee, the consensus was that students should be invited only when items of particular concern to them are to be considered.

In preparation for R-I-S Conference for 1966, the Committee directed that a questionnaire and covering letter be prepared for distribution to the students through the office of the Dean, and to Residents and Interns, through the Director of Resident-Intern Programs in Michigan Hospitals. This questionnaire will solicit information concerning desirable subject matter to be presented at the 1966 R-I-S Conference.

The Committee recommended that communications with new physicians be improved by (a) developing a special MSMS brochure describing services offered to Society members and containing advice on establishing a medical practice, and (b) the MSMS sponsorship of an informational booth at each future Annual Session, staffed by a knowledgeable person, for the purpose of disseminating information concerning MSMS services, and distributing the above-mentioned brochure.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH STATE BAR OF MICHIGAN

Wm. M. LeFevre, M.D., *Chairman*

In accordance with the 1964 House of Delegates Resolution 25, The Council referred to this Committee the matter of the proposed change in the Circuit Court Rules of Michigan having to do with the physician-patient privilege, so that the opposition of the House of Delegates could be transmitted effectively to the State Bar of Michigan.

This Committee has been in contact with the State Bar committee which is proposing to amend the privilege statute. This matter will be discussed at the September, 1965, meeting of the State Bar and subsequently by the State Bar Commissioners. Your Liaison Committee, with advice of Legal Counsel, has transmitted a brief to the State Bar Commissioners vigorously opposing the proposed changes in the law for the basic reason that they would have a pronounced tendency to reduce the likelihood of full disclosure by the patient to his physician of important history essential to adequate treatment.

This Committee is prepared to pursue this matter after the State Bar of Michigan has reviewed its committee's recommendations.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH STATE BOARD OF REGISTRATION IN MEDICINE

Kenneth H. Johnson, M.D., *Chairman*

The 1964 MSMS House of Delegates requested the Michigan State Board of Registration in Medicine to inform the MSMS Council as to (1) whether present Michigan statutes confer adequate enforcement powers upon the Board, and (2) whether sufficient funds are allocated to the Board by the State Legislature to carry out its responsibilities. These questions were raised by Resolution No. 34, which was referred to the Liaison Committee with the State Board of Medicine for implementation.

A meeting with the Board's President, Executive Secretary, and other members was held on January 20, 1965, and attended by MSMS officers, its Legal Counsel, and the Dean of the University of Michigan Medical School. In addition to Resolution No. 34, possible future changes in the Michigan Medical Practice Art were discussed, along with consideration of the implications of repeal of the Basic Science Act, the question of reciprocity in Michigan as regards former osteopaths granted MD licenses in California as a result of the merger between medicine and osteopathy in that State, and the question of recognition in Michigan of certification by the National Board of Medical Examiners in lieu of examinations given by other states. Dean William N. Hubbard, M.D., made several helpful contributions expectantly leading to cooperative activity on the part of the State Board of Registration in connection with the education of medical students.

On the matter of the power of enforcement of the Board of Registration in Medicine, the Executive Secretary stated that exploration with the Attorney General and others had revealed that the Board has sufficient power.

As a result of the Liaison Committee's review of Resolution No. 34 and a review of the wording of the present Medical Practice Act, an additional opinion is being sought of the Michigan Attorney General with respect to the extent of the responsibility of the State Board of Registration in dealing with unprofessional and dishonest conduct under the present terms of the Medical Practice Act. This opinion has not as yet been rendered; when it is, this committee voted to refer the matter to the MSMS Legal Affairs Committee for its guidance. Any further consideration of change in the Michigan Medical Practice Act is deferred pending study of the opinion by the Legal Affairs Committee and the subsequent recommendations of that body.

It was noted that the Board of Registration has been authorized to add to its investigation staff, and it was further noted that Resolution No. 34, calling for the allocation of increased funds to the Board, had been of help to the Board in connection with its budget request, which came up for consideration in July.

Subsequent to the Liaison Committee meeting, the State Board of Registration has directed that an MD license to practice in Michigan be granted by reciprocity to a former osteopath who received his MD in California as a result of the merger there.

Continuing activity of the Liaison Committee it is hoped will include the clarification of wording in the present Medical Practice Act, particularly as regards the "moral turpitude" and "unprofessional conduct," and encouragement of efforts by the State Board to provide information to medical students on the subject of temptations arising in the practice of medicine which, in rare cases, lead to actions of moral turpitude. The Liaison Committee also may in the future serve as a channel to apprise the State Board of powers, duties and functions of the MSMS Judicial Commission as that body becomes active pursuant to the directive of the MSMS House of Delegates.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH THE STATE EXECUTIVE OFFICE

K. H. Johnson, M.D., *Chairman*

The purpose of the Liaison Committee with the State Executive Office is to supply advice and counsel to the Governor of Michigan and his staff with respect to medical matters or matters of interest to the Michigan State Medical Society. The Committee has also functioned, where necessary, to directly transmit official MSMS policy to the chief executives of various State agencies.

State Law requires the Governor to appoint physicians to many boards and commissions, and also vests discretionary power in the Governor to establish such advisory councils and committees as he deems necessary. The Committee has transmitted recommendations for appointment by the Governor on each occasion where health matters were involved.

The Committee has also made specific recommendations to the Governor insofar as proposed medical legislation is concerned, keeping the Executive Office informed of MSMS positions and keeping itself apprised of the Administration's position on all bills of interest to MSMS. In addition, it has expressed Society viewpoints regarding governmental reorganization to the Chief Executive.

A meeting was held for the purpose of becoming acquainted with Michigan's newly appointed Director of Mental Health and his top aides; subsequently, the Committee consulted in the finalization of rules for implementation of the Michigan Community Mental Health Services Act.

The Committee met with the Governor immediately after the federal enactment of the Social Security Amendments of 1965 (Medicare) and, at his suggestion, has taken steps to insure that the views of MSMS will receive full consideration as administrative regulations are developed to implement this and other major new health programs. Each action of the Committee has been reported in detail to The Council.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICAL ASPECTS OF ORGANIZED ATHLETICS

James S. Feurig, M.D., *Chairman*

This Committee was appointed at the request of the 1964 House of Delegates. The Chairman and members of the Committee are men who have been involved locally in the medical aspects of athletic programs.

The Committee has gained information from the AMA Committee and national conferences on the medical aspects of organized athletics. An early meeting is planned to develop specific Michigan recommendations for dissemination to component medical societies, and to consider possible state-wide activities.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee

MEDICARE COMMITTEE

B. M. Harris, M.D., *Chairman*

As requested by The Council, this Committee met with representatives of the Veterans Administration to discuss revisions of the Veterans Home Town Care Program.

Five important items were agreed upon and were forwarded to The Council for approval. These items are as follows:

1. It was agreed that a recommendation will be made to the Veterans Administration in Washington that the Michigan RVS be adopted, with a $5 conversion factor.
2. It was agreed that in unusual cases special reports would be received by VA, thus giving individual consideration to special services.
3. It was agreed that the Michigan RVS method of determining amount of payment for psychotherapy service, based on time, was a method superior to the VA recommendation that a psychotherapy fee be differentiated depending on whether the care was "supportive" or "intensive." If the VA chooses the latter method it would be necessary for the VA to define the words in contract terms.
4. It was agreed that items of service peculiar to the VA would have to be included in any new VA schedule.
5. It was agreed that the schedule originally proposed by the VA was not acceptable because it was based on the California RVS. The reason for preferring the Michigan RVS is that MSMS is aiming at a uniform service index for all agencies or divisions of government, in addition to the fact that a single conversion factor can be applied to the Michigan RVS.

It was further agreed that the local VA office would recommend to the Washington office that the Michigan RVS with a $5 conversion factor become the fee schedule for the fiscal 1966-67 budget beginning July 1, 1966.

These items of agreement were approved by The Council at its meeting of December 16, 1964.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee

COMMITTEE ON MEDICINE AND RELIGION

R. L. Rapport, M.D., *Chairman*

The Medicine and Religion Committee of the Michigan State Medical Society met on four occasions during 1965.

The Committee gave emphasis to the recommendation that all County Medical Societies initiate programs for regular cooperative meetings with the clergy. Such committees have been formed in twenty-seven areas throughout the state.

These meetings, ranging from small "get-togethers" to dinner meetings with as many as 450 participants, signify the interest in this program.

The Committee has actively participated in the planning of the Medicine and Religion Convocation which opens the Centennial Session of the Michigan State Medical Society on Sunday, September 19 at Ford Auditorium in Detroit. At this Convocation a panel of noted men—William C. Menninger, M.D., the Reverend John Weaver and the Rev. Paul McCleave will discuss the subject of "Today's Medicine and the Whole Man." Much interest has been shown in this program and the Committee is anticipating a large attendance on this occasion.

Members of the Committee will be in attendance at the Medicine and Religion Exhibit at Cobo Hall on Tuesday, Wednesday and Thursday during the Centennial Session.

Great cooperation has existed between the State Medicine and Religion Committee and Reverend Paul McCleave and Mr. Charles Hubbard of the American Medical Association Medicine and Religion staff.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee

COMMITTEE ON NURSING

R. J. Mason, M.D., *Chairman*

The main objective of this Committee has been to create a better understanding between the Michigan State Medical Society and the Michigan Nurses Association, and to create a forum for discussion of mutual problems. This has been accomplished.

The liaison Committee, after much study, has developed both a "general statement" and a list of "dependent nursing functions" and "emergency independent nursing functions."

The general statement and lists of functions have been reviewed by the MNA Board and the MSMS Council and endorsed by both.

MSMS Legal Counsel, after exhaustive review of the list of functions, rendered the following opinion to the Council: "I feel that the two so-called independent nursing functions mentioned . . . may properly and legally be recognized as such as long, but only as long, as they are confined to special and emergency situations as life-saving measures and administered by those having adequate training. Likewise, I believe that the seven listed independent nursing functions are not legally objectionable as such, bearing in mind that they are predicated upon the assumption that adequate training has been given and that the primary responsibility continues to be that of the doctor."

The statement, and the lists of functions, follow:

The Registered Nurse, through training and experience, should be considered an integral component of the total medical team in the care and welfare of patients. The functions and responsibilities fulfilled by a Registered Nurse are on a different level from the functions and responsibilities conferred by an MD degree, and these professional practitioners complement each other in their respective spheres of total patient care.

It is implied and understood that the Registered Nurse, in performing certain designated dependent nursing functions, will have received specialized training and instruction in these dependent functions, and that the execution of any new functions will be implemented only after these new skills have been acquired through training.

In general an MD will advise and direct an RN in these dependent nursing functions, yet certain special and emergency situations may arise where the trained RN must exercise these new skills and sound judgment, as a lifesaving measure, without specific MD direction.

There are two major areas of nursing practice, one dependent on the physician's orders, and the other not requiring specific orders of a physician.

The following have become dependent nursing functions in many institutions whereas formerly they were definitely medical functions:

(1) *Administration of investigational drugs.* A nurse may administer a new or non-official or investigational drug on the direct written order of a physician, provided the physician assumes the full responsibility for the action or interaction of the drug or drugs. A nurse may properly refuse to administer an investigational drug if there is a lack of definitive information as to its reaction or interaction and if adequate medical supervision is not immediately available.

(2) *Venepuncture and intravenous administration of a foreign substance.* A nurse, after definite instruction and on the direct order of a physician, will be permitted to do a venepuncture and intravenous injection.

(3) *Intratracheal suction.*

A. A blind intubation will be permitted as a dependent function after training.

B. Tracheal tube aspiration, after explicit direction and training, may be permitted.

Training, as defined by this Committee, combines theoretical information, plus actual supervised clinical practice, to the point where both the nursing and the medical staffs are in agreement on the proficiency of a trainee to perform a particular act.

(4) *General anesthesia.* A nurse not trained in the administration of general anesthesia should not be required to administer general anesthesia.

(5) *Vaginal examination.* After instruction and demonstration, a nurse will be permitted to do vaginal examinations only as part of a procedure for securing cervical smears and cultures.

(6) *Inhalation therapy.* Administration of inhalation therapy will be permitted to be given by registered nurses after due and proper training.

(7) *Levine Tubes (nasal-gastric).* Insertion of Levine Tubes in infants and children will be permitted only after additional training.

Certain dependent nursing functions are emerging as independent nursing functions in emergency situations. These include:

(1) *Closed chest cardiac massage.* The indications, limitations, technique, and complications of the procedure, as well as the underlying physiology, must be thoroughly understood. This requires special training and instruction.

(2) *Mouth-to-mouth resuscitation.* The exact technique and underlying physiology of the procedure must be thoroughly understood through instruction and demonstration. This dependent function is usually an emergency measure and sound judgment should dictate prompt action.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee

COMMITTEE ON REHABILITATION

S. D. Steiner, M.D., *Chairman*

This Committee met twice as follows—November 11, 1964, and June 3, 1965. Our main work consisted of the development of a Directory of Michigan Medical Facilities for the Physically Impaired, which was based on the survey conducted by the Committee last year.

The purpose of the directory is to encourage maximum utilization of rehabilitation facilities by Michigan physicians, when appropriate to their patients' needs.

This directory, covering 116 facilities, has been completed. The Committee has recommended to The Council that it be published in looseleaf form so that it can be updated from time to time, and also that the Directory be given the widest possible distribution to Michigan physicians.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

RELATIVE VALUE STUDY COMMITTEE

A. J. NEERKEN, M.D., *Chairman*

As instructed by both the 1963 and the 1964 MSMS House of Delegates, the Relative Value Study Committee completed its task of studying the matter of alleged inequities in the 1961 Michigan Relative Value Study.

Lengthy conferences were held with representatives of major medical specialty organizations and with the Michigan Branch of the American Academy of General Practice.

Several sections of the 1961 Relative Value Study were completely rewritten and numerous changes were made in others.

It is the belief of the Committee that the new RVS is an equitable evaluation of current professional medical services in Michigan.

The Committee has recommended to The Council that, in compliance with instructions from the House of Delegates, copies of this new RVS be sent to Michigan Medical Service for monetary interpretation only, with the request that MMS report its findings to the 1965 House of Delegates.

The Committee has further recommended to The Council that this new RVS be distributed to all delegates in advance of the 1965 meeting of the House of Delegates.

The Committee has also recommended to The Council that the new RVS be sent to all those representatives of the major specialty groups and the Michigan Branch of the American Academy of General Practice who conferred with the Committee over the past year.

The Committee expresses its deep appreciation to all those who gave so generously of their time in lengthy week-end conferences to assist the Committee in its work and thanks particularly Mr. Richard Campau of the Michigan State Medical Society staff for his conscientious help.

THE REFERENCE COMMITTEE on Reports of Special Committees, D. N. Sweeny, Jr., M.D., Chairman, presented the following report:

"Twenty-five members of the Michigan State Medical Society attended the Reference Committee meeting and offered testimony on these two items. A majority of those present favored adoption of both the report and its appended schedule, since in their opinion the Michigan Relative Value Study 1965 represented an equitable relationship between the various professional services provided by the physicians in Michigan in the fields of medicine, surgery, radiology and pathology. It is our understanding that it is the intention of the Study Committee that this Michigan Relative Value Study 1965 is to replace the Relative Value Study 1961 adopted by the House of Delegates.

"The report and the Relative Value Study was circulated to all Delegates in advance of this 1965 meeting of the House of Delegates. It was also sent to Michigan Medical Service for its evaluation of the probable effect of the schedule on that corporation if it were to operate under its provisions.

"Representatives of Michigan Medical Service testified to the inability of that corporation to implement this Relative Value Study without an accompanying rate increase.

"No official representative of any of the major specialty groups or of the Michigan branch of the Academy of General Practice appeared to testify.

"We regret that the schedule of the Michigan Relative Value Study 1965 has neither an explanatory preface nor an index, both of which would be helpful in the use of this document. We urge that these be added.

"We are impressed with the tremendous amount of work, thought and talent involved in the compilation of the Michigan Relative Value Study. This House of Delegates is indebted to the Relative Value Study Committee men and those who helped them in their deliberations for this devoted service to the Michigan State Medical Society and the patients they serve.

"We recommend adoption of the Report of the Relative Value Study Committee 1964-65 and the Michigan Relative Value Study 1965, and we further recommend that the Relative Value Study Committee be a continuing Committee charged with the re-evaluation of the Michigan Relative Value Study at suitable intervals."

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON RETIREMENT PLAN

R. K. WHITELEY, M.D., *Chairman*

This Committee was created to study retirement plans and, if feasible, to develop an MSMS-sponsored retirement plan, for MSMS members.

Last year, after considerable study of existing plans, the Committee decided not to recommend sponsorship of an MSMS plan because of other fine plans already available to MSMS members. However, the Committee reviewed a proposed plan submitted to it by a special consultant. The Committee believed the plan had merit and even though it did not recommend MSMS sponsorship or operation of the plan, recommended to The Council that detailed information on the plan be submitted to MSMS members for their information. The Council requested more detailed information regarding the proposed consultant's plan and the matter is now in the hands of The Council, the Committee having completed its work.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE TO STUDY ESTABLISHMENT OF MSMS SERVICE CORPORATION

OLIVER B. MCGILLICUDDY, M.D., *Chairman*

Last year we reported to you that the matter of the advisability of MSMS establishing a separate corporation for the purpose of providing special services to its members was under study by a tax consultant, as authorized by The Council.

The tax consultant recommends that no action be taken at this time because Internal Revenue Service rulings regarding unrelated income of business leagues have not been finalized.

Therefore the Committee requests that it be dissolved, since the matter is in the hands of The Council, which will take further action at the appropriate time.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE TO STUDY WORKMEN'S COMPENSATION

WM. JEND, JR., M.D., *Chairman*

The stated purpose of this Committee has been to work toward strengthening administration of the medical aspects of workmen's compensation in Michigan.

In this Committee's Annual Report for 1963-1964 we noted that a Legislative Interim Study Committee was in the process of preparing amendatory legislation at the time of the 1964 MSMS annual session. Our Committee transmitted five specific recommendations to the Legislative Committee and subsequently placed these same recommendations before a special Governor's Study Commission. In addition, a meeting was held with the Director of the Workmen's Compensation Department, and a state Chamber of Commerce state-wide meeting was monitored by MSMS staff, all prior to the introduction of legislation in the 1965 Legislative session.

Our Committee recommended as key factors in improving the administration of workmen's compensation as it relates to the medical profession: (1) creation of the office of Medical Director in the Workmen's Compensation Department; (2) appointment of a medical advisory committee to assist the Director of the Department; (3) increased emphasis upon rehabilitation programs; and (4) greater use of impartial medical authorities to resolve issues of medical fact or opinion. These improvements could probably be accomplished without additional legislation.

In connection with rehabilitation, the Workmen's Compensation Department Director established a Rehabilitation Study Group, to which was appointed Dr. William Jend, Jr. No action has been taken as yet in the area of a Department Medical Director, but considerable evidence has been noted that members of the State Legislature are interested in, and will support, this concept.

Major amendments to the Michigan Workmen's Compensation Act were passed by the 1965 Legislature. Several proposals in the area of "choice of physicians" were put forward, running the gamut from unlimited free choice to an opportunity to change physician after 60 days of treatment from an employer-selected physician.

MSMS' Committee, at the request of the Legal Affairs Committee, expressed the view that effort should be made to retain the employer's right to choose the physician. The final version of the amended law was the closest to this position which was offered for consideration.

The 1965 amendments to the Law, for the first time, extended workmen's compensation coverage to employers of one or more persons, thus covering many physicians. An explanation of this action will be published in *Michigan Medicine.*

Continuing activity of the Committee to Study Workmen's Compensation will include encouragement of emphasis on rehabilitative services and intensified efforts to bring about the creation of the office of Medical Director and appointment of a Medical Advisory Committee.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON UNIFORM FEE SCHEDULE FOR GOVERNMENTAL WELFARE AGENCIES

Wm. M. LeFevre, M.D., *Chairman*

At the request of The Council this Committee studied the matter of revising the 1959 Michigan Uniform Fee Schedule for Governmental Welfare Agencies (green book), based on the policy that wards of government be not treated as indigents, and that physicians be compensated by the usual and fair fee for their services.

After much deliberation the Committee recommended to The Council in December of 1964 that MSMS adopt a new Uniform Fee Schedule for Governmental Welfare Agencies, based on the 1961 Michigan Relative Value Scale with a monetary factor of $5 applying to all sections.

This recommendation was approved by The Council at its meeting of December 16, 1964. The Council authorized the reprinting of the Revised Uniform Fee Schedule using the Michigan RVS code numbers and units based on the $5 conversion factor.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON VETERANS AFFAIRS

William Bromme, M.D., *Chairman*

Several years ago when this Committee was renamed, it was assigned the additional function of serving to negotiate fee schedule with Veterans Administration in the Home Town Care Program for service connected veterans.

During the year past this problem was reassigned to a different committee and so there has been no need for a meeting of the Committee on Veterans Affairs.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

15. Annual Reports of Standing Committees.

ADVISORY COMMITTEE OF PAST PRESIDENTS

O. J. Johnson, M.D., *Chairman*

The Committee met September 23, 1964, in Detroit, with an attendance of 8.

The Committee expressed its appreciation and thanks to The Council for adopting its suggestion that there be more dignity and ceremony to the inauguration of the president.

The Committee expressed appreciation to the House of Delegates for granting automatic Life Membership and waiver of dues to all past presidents.

The Committee recommended that past chairmen of The Council and past speakers of the MSMS House of Delegates be added to the Advisory Committee of Past Presidents.

The Committee discussed the M.D.'s image of today and the need for a united profession. It was the opinion that the accelerated activity in the organization during the past year would be felt in the years ahead.

THE REFERENCE COMMITTEE on Reports of Standing Committees, J. R. Pedden, M.D., Chairman, recommended acceptance of this report.

THE HOUSE adopted the report of the Reference Committee.

ADVISORY COMMITTEE TO MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

G. E. Millard, M.D., *Chairman*

There was one meeting of the Advisory Committee during the past year. A meeting is scheduled for this Fall.

The Advisory Committee has been in close contact with the officers of the Society throughout the year. It has been a good year for them. The officers are becoming increasingly better and more capable leaders as their experience grows. The National office of the American Association of Medical Assistants sent officers to participate in a nationally directed Leadership Training Seminar which was held in Port Huron, June 13.

On June 25 the Michigan State Medical Assistants Society held its first certification examinations at the Highland Park Junior College on behalf of the national level which is now in its third year of certification examinations.

The Upper Peninsular Seminar will be held July 17 and 18 in Marquette. This was very well attended last year and they expect more members to participate this summer.

Their recruitment program appears to be going into higher gear and will be tied more closely to the county and individual physician target. On the national level these ladies are showing an increasing amount of political savvy and they are becoming more effective in A.A.M.A.

The chairman is running this fall as a candidate again for national advisory position for three years.

I wish to thank the members of the Advisory Committee for the time that they have given to this endeavor on several occasions in the past year.

THE REFERENCE COMMITTEE on Reports of Standing Committees, J. R. Pedden, M.D., Chairman, recommended acceptance of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON AGING

A. Hazen Price, M.D., *Chairman*

The Committee on Aging met three times during 1964-1965, once in Lansing and twice in Ann Arbor. The meetings were well attended with a spirited discussion each time.

We were saddened by the death of a valued committee member, a fine gentleman and physician, Doctor Jack Rom. He was intensely interested in the problems of older people and will be greatly missed, not only by the patients under his care but also his many friends and associates.

The Governor's Health Task Force for the Aging received an extensive review after the report was presented by Doctor Vlado Getting, the Chairman and a member of our Committee. While the report received some criticism from members of the Executive Staff of our State Society, most of it was heartily endorsed by members of our committee. Many of the suggestions made to the Governor were included in his report to the Legislature and they, in turn, implemented some in the form of statutory rulings.

The Nursing Home Accreditation Program was again presented by Doctor Fred Swartz, the Chairman of the A.M.A. Committee on Aging, with a favorable report on how well Michigan was participating. Many meetings have been held in different parts of the country in an effort to bring about a closer relationship between the physician and the Nursing Administration through an educational program. A Regional Conference, sponsored by the Michigan Gerontological Society of which Doctor V. K. Volk is president, was held at the Dearborn Inn during June, 1965. It was attended by 200 interested persons who heard several valuable presentations on ways to improve the care of patients in Nursing Homes.

Several members of our committee attended and some participated in the A.M.A. Conference on Aging and Long Term Care in Chicago during February, 1965. Some of the medical aspects of aging were presented to a postgraduate meeting in Traverse City by Doctor R. Fitts on the invitation of John Sheldon, M.D., Director of Postgraduate Education, U-M. It is hoped others will be held this coming year.

A resolution to improve the Kerr Mills Act in Michigan was passed by the House of Delegates in September, 1964. Several suggestions were made to the Legal Affairs Committee which was instrumental in having new laws passed favorable to our aging population.

After a lengthy discussion of President Johnson's Committee on Heart Disease, Stroke and Cancer, it was agreed that the medical profession was also in favor of making available to all people the many advances in medical research. We felt, however, that the establishment of Regional Medical Research Centers is not necessarily the most effective way of making this knowledge available to all the people. Many physicians and community hospitals will not be near these centers and adequate provision must be made for the extension of a high quality of medical care to those relatively isolated areas.

During the next year consideration will be given to ways of how best the medical profession can implement the new Federal Insurance Program.

THE REFERENCE COMMITTEE on Reports of Standing Committees, J. R. Pedden, M.D., Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON BLOOD BANKS

Leo W. Walker, M.D., *Chairman*

There were no formal meetings of the Blood Bank Committee. Members of the committee worked with the Michigan Society of Pathologists in having introduced in the legislature a bill to declare blood banking a service. This bill would exempt blood transfusions from the provisions of the Federal Trade Commission and Michigan statutes dealing with product warranty. The bill died in committee but will be introduced again next year.

THE REFERENCE COMMITTEE on Reports of Standing Committees, J. R. Pedden, M.D., Chairman, recommended approval of the report with the following statement: "Because of the urgency of the matter introduced by Public Law 89-97, this Committee should continue to meet at its earliest convenience to advise on the matter of the bill to exempt blood transfusions from the provisions of the Federal Trade Commission and Michigan Statutes dealing with product warranty."

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON CANCER CONTROL

H. J. VandenBerg, M.D., *Chairman*

The MSMS Committee on Cancer Control reviewed its scope and purpose and concluded that it should continue to function inasmuch as it was the only real source of information on cancer matters to the House of Delegates.

In the future, the Committee would brief and inform the House of Delegates on any activities of cancer that MSMS might reasonably take a position on; be a source of information re governmental, scientific and technical changes, diagnostic and educational matters concerned with cancer; and take an active part in setting forth policy re the new cancer treatment centers—where they are to be located and how they will function, etc.

The Committee recommends that its name be changed to "Cancer Committee."

The members of this Committee who are delegate-members of the Michigan Cancer Coordinating Committee have consulted on policy matters with the MSMS Committee and have served admirably in their capacity as MSMS representatives.

The Council approved this Committee's recommendation that, because of the clustering of leukemia and lymphoma cases, these diseases should be treated as epidemic, that leukemia and lymphomas be made reportable diseases in order to facilitate the epidemiological investigations which are clearly justified.

THE REFERENCE COMMITTEE on Reports of Standing Committees, J. R. Pedden, M.D., Chairman, recommended acceptance of the report, amending the third paragraph to read: "The Committee recommends that its name be changed to 'Committee on Cancer'."

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON CARDIAC DISEASE CONTROL

S. E. Chapin, M.D., *Chairman*

The Committee met on November 11, 1964, and received reports from the various agencies active in cardiac disease control.

The Michigan Heart Association reported the completion of the rheumatic fever desk reference cards and arrangements were made for its distribution. The first copies of a new set of reference cards on the subject of strokes were presented to the Committee. The distribution of these cards would be done in the same manner as the rheumatic fever cards. The Heart Association reported further that a set of similar cards on the subject of coronary artery disease was being developed.

The Committee reviewed that activity in the various Rheumatic Fever Centers in the State. A financial report was received and Michigan Heart Association support of these Centers was reaffirmed.

A strong recommendation was developed concerning the continuation of the current program of bi-cillin for the prevention of rheumatic fever and heart disease. Copies of this recommendation were sent to the Governor and the State Health Commissioner.

The Committee agreed to participate with the Nutrition Committee of the Michigan Heart Association in a survey of both physicians and the public concerning attitudes towards nutrition, diet and its relationship to heart disease.

The Committee urged the Michigan Heart Association to gather materials and experience in the operation of Intensive Care Units for coronary artery disease patients. This information was to be made available to all hospitals in the State.

The Chairman of the Cardiac Disease Control Committee represented the Michigan State Medical Society at the Second National Conference on Cardio-vascular Disease held in Washington, D. C., late in November, 1964. Representatives from the Michigan Department of Health and the Michigan Heart Association made up the delegation.

The main recommendation emerging from the National Conference was that each State hold a similar conference for the purpose of evaluating the resources available to its citizens for the diagnosis, care and prevention of cardiovascular disease. As of the date of this report, the representatives of the State Medical Society, the Heart Association and the Health Department are arranging this conference for Saturday, November 6, 1965, in Detroit.

A Steering Committee for this conference is being chosen with representatives from all of the State Professional Organizations who play a vital role in the care of patients with cardio-vascular disease and it includes the Michigan Health Council. The members of the Michigan State Medical Society Cardiac Disease Control Committee will all be invited to the organization meeting of this Steering Committee.

It was the feeling of the Committee that efforts in cardiac disease control were being carried out effectively in the State of Michigan by all agencies working in this field. Continued liaison with these agencies will be the main purpose of this Committee.

THE REFERENCE COMMITTEE on Reports of Standing Committees, J. R. Pedden, M.D., Chairman, recommended acceptance of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON CHILD WELFARE

W. Kaye Locklin, M.D., *Chairman*

Vaccine Study

The study as proposed by the Committee of last year regarding the status of immunization of children throughout the state is still in the organizational and planning phase with the support of the University of Michigan School of Public Health. It is hoped that something concrete will be accomplished in the coming year.

Tetracycline

The Committee was made aware of the permanent staining of teeth in children due to tetracyclines. The Committee has recommended that an article on the problem of permanent staining of teeth in children due to Tetracycline be prepared and submitted to the scientific editor for use in various publications of the Michigan State Medical Society.

Guthrie Test

The Committee went on record as opposing the 1965 Michigan Legislative Bill 2120—requiring the administration of a phenylketonuria test on new born infants, because the committee believed that this is not a subject for mandatory legislation at the present time. However, the Committee on Child Welfare encourages all hospitals in the state to cooperate with the Michigan Department of Health on a voluntary basis in the PKU testing program.

School Health Problems

The Committee received a report on the pilot program that has as its objective to gain better communication with local people on school health problems. Some of the problems brought out were: (a) some things that are already law are not known by some physicians, (b) some physicians confuse school health and public health with communicable health, (c) the level of school health teaching is low, and (d) there is interference with school health programs. The pilot program is continuing in its effort to develop effective means of solving these problems.

Project Head Start

After considerable study and discussion, the Committee on Child Welfare recommends that all Michigan component medical societies be alerted to the fact that Project Head Start is in operation and urges county societies to make a strong effort to be sure that all the children involved have an excellent health appraisal and good follow-up and that this be done in cooperation with a local sponsoring agency. (Explanatory Note): Project Head Start, the Federal government's crash program for culturally deprived children, is a nationwide pre-school program which is part of the war on poverty. This summer more than 100,000 4- and 5-year-olds from 300 communities will be enrolled in eight-week sessions aimed to: (1) improve their health and physical abilities, (2) develop their self-confidence, (3) provide a wide range of classroom experience and field trips, and (4) establish joint activities with their parents.

The program is in two parts: the crash program for preschool children, who enter school next fall, which involves an expenditure of $17 million; the second part is for children who will enter school a year from next August. The Office of Economic Opportunity will pay 90 per cent of the cost where local communities organize and operate such a two-month program this summer, the local community to furnish the remainder in either cash or kind. The average cost per child is estimated at $85 per month.

Measles Campaign

The Committee went on record as approving and recommending that all doctors of medicine taking care of children make a strong effort to immunize all susceptible children from measles. The program as sponsored by the Michigan State Medical Society through the cooperation of Merck Sharp & Dohme was reviewed and highly lauded.

Sub-Committee on Ophthalmology

The Committee held one meeting on March 10, 1965. The past year has revealed considerable growth of the school screening program in Michigan. The Research Project with the cooperation of the University of Michigan School of Health on the high incidence of children who fail vision tests in the culturally deprived areas of Metropolitan Detroit is taking shape and should result in useful information this coming year. Pre-school vision screening tests to include the Hirschberg test are continuing and the subcommittee recommends that as a pilot study a key group of technicians be taught to do the Hirschberg test and a survey of the results in the schools be made. Further testing such as the crowding phenomenon and school screening procedures are still under study for further development.

THE REFERENCE COMMITTEE on Reports of Standing Committees, J. R. Pedden, M.D., Chairman, recommended acceptance of the report noting that PKU testing is now mandatory by law. The Reference Committee further recommended that the general level of immunization obtained in children be used as a goal for immunization in older age groups.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON DIABETES

W. M. LeFevre, M.D., *Chairman*

Your Committee met on several occasions and took an active part in the discussions necessary to the organization of the program for diabetes detection. This program, as in the past few years, was handled by an organization known as the Michigan Diabetes Detection Program and was run by a coalition formed by representatives of the Michigan Diabetes Association, Michigan Department of Health, Michigan Society of Pathologists and the Michigan State Medical Society.

Mass testing programs were instituted at various points in the State, always with the approval and usually at the request of the local county medical society. With the Clinitron set at 115 mgm per cent all blood tests over this concentration were run through the Auto-analyzer. The results of the last procedure were forwarded to the physician chosen by the recipient of the test. A letter to this effect was sent to each person with an abnormal test which stated that the diagnosis of the presence or absence of diabetes would be made by the physician of his choice. Another letter was sent to the physician giving the actual blood level of sugar concentration and requesting him to add such procedures as he considered necessary to make a final diagnosis.

The Clinitron and Auto-analyzer are expensive pieces of equipment and are currently being made available through the Michigan Department of Health. It is to be noted that only by the use of such devices can testings be done on a large scale. The Committee came to the conclusion several years ago that urinalysis as a detection method was unreliable and our detection programs since that time have been largely based on blood analysis.

This report need not include all of the data obtained but a few figures will demonstrate the extent to which we, in Michigan, are going in this field of case-finding. During 1964, a total of 78,676 tests were made resulting in the discovery of 354 new cases of frank diabetes and 255 cases classified as potential. It is interesting to note that 654 persons presented themselves for testing who proved later to be known diabetics. These cases are eliminated from the total reported as questionable because they cloud the issue since we are looking for new cases requiring treatment, not old ones who might be checking up on their doctor.

This figure of almost 80,000 tests puts Michigan ahead of most states in this program. In 1963, Michigan did 20 per cent of all the testing in the United States with 5 per cent of the population.

The Committee feels that cooperation with the Program on the part of the Michigan State Medical Society should be continued. Since all the members of the Program are physicians and members of the State Medical Society, it may not be necessary to have the MSMS Diabetes Committee appointed in 1965-66. The Michigan State Medical Society is represented on the Program by one vote, so The Council should appoint an official representative and an alternate who will act in that capacity.

THE REFERENCE COMMITTEE on Reports of Standing Committees, J. R. Pedden, M.D., Chairman, accepted the report with the recommendation that the Committee on Diabetes be continued.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON ETHICS

E. A. Osius, M.D., *Chairman*

The Committee had no work referred to it during the past year and, therefore, no meetings were held.

This speaks well for the ethics of the Michigan State Medical Society members and is indeed a good record.

THE REFERENCE COMMITTEE on Reports of Standing Committees, J. R. Pedden, M.D., Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON HIGHWAY ACCIDENT PREVENTION

J. R. Rodger, M.D., *Chairman*

The Committee had one meeting, there not being enough urgent business in the spring to justify a second meeting when the headquarters staff was loaded with legislative responsibilities.

The Committee made one of the most important steps in its history by urging the formation of a Medical Advisory Committee to the Secretary of State. For a variety of reasons the Local County Medical Society Advisory Committees which have been in existence for several years have not been as effective as hoped for. Successful state level advisory boards are operating in several of the states, and the formation of a Medical Advisory Board was requested by the Secretary of State. The MSMS Council has submitted to the Secretary of State the names of doctors of medicine in the Lansing area who would serve in such a capacity, provided that sufficient funds are appropriated for implementation. The Board would meet in Lansing possibly twice a month to examine physicians' statements, and to act as a health consultant group on the physical aspects of driver licensure.

Other aspects of driver safety were discussed with members from the MSU Traffic Safety Center and from the Department of State. Two members of the Committee attended the National Conference on Medical Aspects of Driver Training and Driver Licensing held in Chicago in November. The Chairman took part in the MSU Traffic Safety Center's Conference for the Pilot Club International Safety Chairmen, and spent a day of his vacation time in Tucson speaking on traffic safety subjects before TV, Chamber of Commerce and hospital staff audiences.

THE REFERENCE COMMITTEE on Reports of Standing Committees, J. R. Pedden, M.D., Chairman, accepted the report noting the highway death toll in Michigan and the Governor's interest in improving the situation. The Reference Committee "hoped that the Committee will meet more frequently and investigate the subject more thoroughly in the coming year."

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON IODIZED SALT

B. E. Brush, M.D., *Chairman*

The Committee on Iodized Salt has continued to do a courageous job in a tremendously important area of preventive medicine with only meager financial support.

In other countries, laws have been passed to ensure the use of iodized salt and thus prevent endemic goiter. Our path in Michigan has been that of repeated surveys and campaigns to attain this same goal.

The Committee is now anxious to do a better job for the people of Michigan. We have some research projects, campaigns, reports, etc., all of which need sounder financing than we have had in the past.

It has been suggested by William H. Beierwaltes, M.D., approved by the Committee, and received by the MSMS Council, that a Michigan Thyroid Association be formed.

Upon recommendation of the MSMS Council, the 1965-1966 Committee on Iodized Salt will submit to The Council for its consideration, a detailed proposal with supporting data. Also, a proposed budget. The Committee is hopeful that a Michigan Thyroid Association will be formed and be in operation during the year 1966 as this will enable us to carry out many of the projects and studies which we have wanted to do for such a long time, and which we feel are very important to accomplish in order to keep our State the leader in this field.

THE REFERENCE COMMITTEE on Reports of Standing Committees, J. R. Pedden, M.D., Chairman, recommended acceptance of the report, commending the committee for the great effort expended in the discharge of its duties.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON LEGAL AFFAIRS

Otto K. Engelke, M.D., *Chairman*

Over one thousand legislative proposals were introduced this year in the State House of Representatives alone, and an additional six hundred and eighty-four bills were proposed by members of the State Senate. Of this record number, one hundred and thirty-three (also a record number) were singled out for detailed analysis by the MSMS Legal Affairs Committee as being particularly pertinent to the health interests of the people of Michigan.

To a greater extent than in any previous year, the Legal Affairs Committee would like to commend the membership of MSMS for their support in bringing needed facts regarding health legislation to the attention of legislators. Not only were more bills affecting Medicine introduced this year than in previous years, but they were placed before a Legislature composed in the main of first-term Senators and Representatives.

Michigan's physicians rose to the challenge. Many attended a necessary emergency conference on health legislation held in Lansing in mid-April. Literally hundreds of physicians made a point of discussing vitally important bills with their legislators in their own communities. Many county medical societies sent delegations to Lansing to meet with their county lawmakers at MSMS headquarters. Ophthalmologists, pathologists, orthopedic men, public health doctors and many other specialty groups contributed their advices and efforts to support good legislation and oppose undesirable bills.

The Legal Affairs Committee itself held five formal meetings in a period of five months, and the MSMS staff assisted in the preparation of ten bulletins to the entire MSMS membership so that all physicians could be currently informed of legislative developments. More information regarding the Lansing scene was furnished to Michigan's physicians during the first six months of 1965 than during any other comparable period in many years.

It became necessary, as the legislative session progressed, to augment the MSMS Legislative Agent's activities by temporarily assigning two additional staff members to assist him in the State Capitol. On many occasions simultaneous hearings on bills of great importance were being held in three or more committee rooms. The Chairman and members of the Legal Affairs Committee, and many other physicians, gave unselfishly of their time and talents to personally testify before legislative committees, some making the trip to Lansing on several occasions.

As a result of all of this activity it was possible on May 17 to report to the entire membership of MSMS via *Medigram* that the Legislature had up to that time, with one exception, taken those actions recommended by MSMS on bills assigned their highest priority by the Society. We are in a position now to review our gains and losses at the time of Legislative recess. The overall score looks good.

The particular exception noted in the May 17 bulletin, a proposal to widely expand the privileges of chiropractors, was rejected by the Legislature ten days later. A second exception, however, developed subsequently when the Legislature, which had rejected a proposal to commit the State to the construction of an osteopathic college, agreed by amending an appropriations bill to authorize its appropriating committees to make a "feasibility study" of such a project. This amended bill leaves the proposed osteopathic college to an uncertain fate in committee so that MSMS must continue during 1965 to inform legislators why the best health interests would not be served by creation of such a college.

Furthermore, it must be noted that in some respects MSMS recommendations were not fully accepted by the Legislature. In the case of some bills, however, compromises were achieved which represented significant improvements over the original proposals. For example, the Legislature voted to permit podiatrists the use of the designation "physician and surgeon" but stipulated that such use would not in any way expand their practice privileges and also flatly provided that if such terms were used by a podiatrist the words "of the foot" *must* be used in conjunction therewith, and printed in the same size. In no case was any legislation passed which would expand practice privileges of chiropractors, optometrists, podiatrists, or psychologists.

The Legal Affairs Committee acknowledged both the magnificent support received from members of the Society and the splendid work done by assigned MSMS staff. The Committee also has been impressed by the thoughtful and deliberative actions of the State Legislature. MSMS positions were respectfully considered, as new and experienced legislators alike demonstrated a sincere interest in doing what was best. Representatives of both political parties supported MSMS' position on key issues. A State Legislature, composed of a heavy majority of Democrats for the first time in decades, clearly demonstrated its desire to enact only sound health legislation.

Of the proposals discussed at the April 24 "Emergency Conference on Health Legislation," action taken on the osteopathic college proposal and the podiatry bill has been reviewed above. The major bill to expand optometric practice privileges (SB 415) was rejected; SB 503, which also contained language expanding optometric practice, was amended to delete this language. SB 503 and SB 500 both passed, permitting recognition of optometrists by governmental programs and health insurance programs for those services which they have heretofore been authorized to perform. A bill (SB 78) including podiatry services in the Blue Shield Enabling Act was passed; a similar bill (SB 100) dealing with Blue Cross was rejected. All bills dealing with the expansion of, or further recognition of, chiropractic services were rejected.

Of the two psychology bills considered, HB 2503, which would have drastically altered the "grandfather clause," was rejected; HB 2200 was passed, but will not expand the legal practices of psychologists. Both bills calling for hospital franchising (SB 658 and HB 2899) were rejected. The Legislature also rejected a bill which would have required medical examiners to hold coronor inquests. The governmental reorganization bill, as finally passed, meets the position of MSMS in two major particulars: first, it leaves the powers, duties and functions of the licensing and regulating boards (Board of Registration in Medicine) under the control of the boards, and secondly, it provides for both a Department of Health and a Department of Mental Health. It, however, provides for single policy-making executives at the head of each rather than policy-making boards or commissions as favored by MSMS.

Also on the "plus" side was passage of a bill to liberalize the Medical Assistance to the Aged program by eliminating the lien provision; passage of a bill to license and regulate the practice of physical therapy; addition on dental services under the M.A.A. program; adoption of the Interstate Compact on Mental Health; a bill to require registration of small nursing homes (fewer than four patients); and a bill extending county health department services to the entire State (part of the MSMS Presidents Program) and providing additional funds on a population basis for the operation of the county health departments.

Bills introduced by MSMS which failed to pass, but which are still eligible for consideration during 1966, include further improvements to the M.A.A. Act, extension of the medical examiner system state-wide, repeal of the Basic Science Act, the "product warranty" bill dealing with blood transfusion and organ transplantation, and the bills to increase fees under Crippled Children programs. In the latter case strong indication was given of favorable action during 1966.

The Legislature enacted a bill requiring that a PKU test be given to all Michigan newborns, although MSMS had strongly protested that this was not a proper subject for mandatory legislation and should be left to the voluntary system. Similarly, a bill was passed requiring a tuberculin test prior to school entrance. In the case of both these bills, articles explaining the requirements of the legislation will appear in *Michigan Medicine.*

Other legislative actions included: a change in the manner of selecting members of the Michigan Hospital Advisory Council which fails to name any group, including MSMS, as entitled to nominate members for appointment (this bill was opposed by MSMS); passage of a bill requiring one who sells a medical practice to notify the Board of Registration in Medicine (supported by MSMS); passage of "family planning" bills after accepting MSMS amendments providing that medical advice may only be given by physicians; rejecting a bill proposing massive amendments to the Community Mental Health Services Act (the bill was opposed by MSMS); and rejecting, in the Senate, a house-passed bill which would have levied a tax on the net income of business.

It is important to note that under the terms of the new Michigan Constitution *all* bills which were introduced in 1965, unless formally rejected by vote, are still eligible for consideration during the 1966 legislative session. Essentially this means that the scores of objectionable proposals including those to expand the medical privileges of non-medical groups, will continue to pose a threat to the quality of health care of Michigan's people, and must again be opposed in the second half of the legislative term.

Inasmuch as the State Legislature will return in the fall of 1965, primarily to consider taxation, it can be anticipated that the Legal Affairs Committee will function during 1965 throughout the entire year.

There remains much to be done to develop essential rapport with the new State Senators and State Representatives who must make decisions on these bills. The Legal Affairs Committee strongly urges that all MSMS members, individually and at the county medical society level, utilize the months before January, 1966, to get to know their elected representatives from both political parties. Every legislator should have several sources of information and should be encouraged to seek the advices of physicians who are his personal acquaintances when he must take a stand on complex health issues.

THE REFERENCE COMMITTEE on Reports of Standing Committees, J. R. Pedden, M.D., Chairman, recommended acceptance of the report, commending the committee for the great effort expended in the discharge of its duties.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MATERNAL HEALTH

W. W. Jack, M.D., *Chairman*

The Committee on Maternal Health is able to report another successful year. Three meetings were held, on October 29, 1964, January 7, 1965, both at MSMS headquarters in East Lansing, and one at the Kellogg Gull Lake Biological Station on May 13-14, 1965.

A two-day Conference on Maternal and Perinatal Welfare was held in Flint in March. Outstanding speakers from Michigan and from out-of-state presented a series of papers. There were 232 physicians registered from 32 different counties. The Committee is grateful to the Clara Elizabeth Fund of Flint for the support it gave to this conference.

The Regional Evaluating Committees of the Maternal Mortality Study continued their activity. There were ten such groups throughout the state that were active and 400 doctors attended these various meetings throughout the year. (Central Maternal Mortality Evaluation Subcommittee will not function next year.)

REGIONAL MATERNAL MORTALITY EVALUATION SUBCOMMITTEE MEETINGS

July 1, 1964 - June 30, 1965

	Meetings Held	Total Attendance	Cases Discussed
Wayne County Maternal Mortality Study	9	153	18
Tri-County Regional Maternal Mortality Evaluation Subcommittee	3	71	23
Genesee County Regional Maternal Mortality Evaluation Subcommittee	3	40	17
Kalamazoo County Regional Maternal Mortality Evaluation Subcommittee	3	38	21
Ingham County Regional Maternal Mortality Evaluation Subcommittee	2	28	4
Kent County Regional Maternal Mortality Evaluation Subcommittee	2	25	7
Muskegon County Regional Maternal Mortality Evaluation Subcommittee	2	20	12
Northwest Lower Michigan Maternal Mortality Evaluation Subcommittee	1	18	2
Central Maternal Mortality Evaluation Subcommittee	4	16	99
Branch County Regional Maternal Mortality Evaluation Subcommittee	1	9	7
TOTAL	30	418	210

This marked the fifteenth year for the Maternal Mortality Study and the Committee is now reporting the accumulated statistics. Our appreciation to the Michigan Department of Health for its continued support of this study is gratefully acknowledged. Efforts to utilize this material continues to be a major effort of the Committee. Several members of the Committee presented material from the study at the Annual Meeting of the MSMS in Detroit in 1964 and at the meeting of the Upper Peninsula Medical Society in Marquette, June 11, 1965.

The Committee continues to distribute Desk Reference Cards covering several aspects of the practice of obstetrics and the resultant complications to Michigan doctors who are practicing obstetrics. In the coming year, the Committee will undertake a study of the effectiveness of this program.

A Michigan Perinatal Mortality Study will be instituted in 1966 in an attempt to permit each hospital to focus its attention on this important problem. The study, as proposed, will permit each hospital or each county to utilize the study if it chooses and in the manner it chooses. The Michigan Department of Health and the Commission on Professional and Hospital Activities of Ann Arbor are cooperating in this study.

At the meeting of the Committee in May at Gull Lake, the several activities of the Committee were discussed in depth and many fine suggestions for improvement resulted. It is felt that the Committee will become an even more active and important one in the coming years.

And lastly, the Committee developed a "Statement on Family Planning," as follows:

> "The Michigan State Medical Society strongly supports the following concept of Family Planning:
>
> "The current interest in various aspects of family planning and the recognition of the importance of human reproduction, including population control, have put emphasis on the responsibility and need for leadership from the medical profession.
>
> "This leadership must manifest itself through counselling with the individual patient in the physician's office and cooperation with organizations whose purposes coincide with, and whose direction is provided by, the medical profession.
>
> "The very personal nature of this advice and counselling in family planning makes it mandatory that consideration be given to the patient's wishes and desires, her ethnic and religious background. The physician or clinic must be prepared to counsel on all the various aspects of family planning, whether in assisting a couple to have a family, or, at the other extreme, in assisting a couple to postpone additions to their family. In the latter regard, expert counselling in the technique of rhythm should be just as readily available as expert advice in the newer forms of family planning."

It is with great appreciation and thanks that the Chairman acknowledges the support and enthusiasm and loyalty of the members and the consultants of the Committee. Without this continuing support, the programs of the Committee would be ineffective.

THE REFERENCE COMMITTEE on Reports of Standing Committees, J. R. Pedden, M.D., Chairman, recommended acceptance of the report with commendation for the diligence the Committee displayed in the discharge of its responsibility.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDIATION

D. R. Boyd, M.D., *Chairman*

No problems arose this year necessitating a meeting of the Committee on Mediation.

THE REFERENCE COMMITTEE on Reports of Standing Committees, J. R. Pedden, M.D., Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICAL SOCIO-ECONOMICS

H. F. Falls, M.D., *Chairman*

Liaison with University of Michigan School of Public Health. The Committee continued its liaison with the U. of M. School of Public Health with regard to two of their current research projects, viz., "Organization and Financing of Community Health Services Throughout Michigan" and "Evaluation of Public Health Practices." The Committee will continue to make available to those in charge of these studies the position and attitudes of MSMS in such matters that concern the medical profession.

Home Care. The Committee continued its study of the economic aspects of home care and other approaches to the matter of meeting patient needs with the most economical and efficient medical facilities available. The Committee expresses support for studies in Michigan that would explore the feasibility of home care coverage by Michigan Medical Service.

Hospital Emergency Room Problem. The Committee contacted the Chairmen of all component medical society economics committees to ask that they review this matter in their area and report their findings and possible recommendations to us. As a result of responses received to date, we have concluded that (1) where problems exist they are peculiar to the hospital(s) concerned; (2) the public's concept of the proper role and function of the hospital emergency room varies with different communities, depending upon size, location, etc.; (3) where problems exist they must be solved by the hospitals and physicians concerned.

The Committee met with Joseph Woosley, Ph.D., Michigan Hospital Service Research Director, who described their study evaluating the function of hospital emergency rooms in 22 Michigan hospitals. We have made arrangements whereby the master design of the study will be sent to each component society economic committee chairman with recommendations that his committee conduct a similar or modified study in his area.

Long Range Planning. The Committee continued its long range planning activities. The Council approved a recommendation to have experts prepare position papers dealing with the environment in which medicine will be practiced in 1980. Topics will include hospitals, health insurance, medical education, other healing arts practitioners, and government. The author of each paper will be invited to appear before the Committee for questioning after the Committee has reviewed his submission. The Committee will appraise each paper to determine which of these trends MSMS should encourage or oppose.

The consensus of the Committee at its July meeting was to accept the request of The Council to expand the scope and function of its activities to include Research and Development along lines as suggested by The Council. Programs underway or in planning stages will be enlarged to fit this broader assignment.

Profile of Michigan Doctors of Medicine Study. This completed study gives basic statistical data on a county basis on all M.D.s in Michigan. Included is information on average age, practice specialty, board certification, and type of practice or employment.

Economic Department. To insure maximum utilization of MSMS staff, The Council broadened the scope of the Economic Department's activity to include full staff responsibility for all committees of MSMS which have medical socio-economic aspects. These include the Committee on Professional Insurance Plans, Committee on Relative Value Study, Committee on Rehabilitation, Committee on Uniform Fee Schedule, Medicare Committee, Committee on Retirement Plans, Committee on Evaluation of Prepaid Medical Services, and the Committee to Study the Establishment of an MSMS Service Corporation. The Committee is pleased that the Department has played a key supportive role in the accomplishments of these committees.

THE REFERENCE COMMITTEE on Reports of Standing Committees, J. R. Pedden, M.D., Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICINE AND OSTEOPATHY

John J. Coury, M.D., *Chairman*

The Committee on Medicine and Osteopathy has had a very active year, obtaining and dispensing information relative to the above.

Many informational meetings were held with county medical societies and hospital staff units throughout the state. An informational seminar with the entire Committee present was held in Grand Rapids at the Officers Conference.

Numerous contacts were made with individual doctors of medicine and doctors of osteopathy. Many legislators and public officials have been contacted and informed of MSMS policy, relative to medicine and osteopathy.

Much effort was carried out informing the public and the legislature that a school of osteopathy in Michigan is not in the best interests of the people of Michigan. This is concurred in by a majority of practicing D.O.s.

All proposals accepted by the House of Delegates in 1964 have been undertaken and some are under continuing research and study.

The Committee on Medicine and Osteopathy again recommends:

(1) That MSMS continue to work toward the ultimate goal of establishing in Michigan a single Medical Practice Act.

(2) That Michigan State Board of Registration in Medicine be asked again to review its decision of denying license to former D.O.s who have been licensed as M.D.s in the state of California.

(3) That the Committee on Medicine and Osteopathy be permitted to continue to explore and study plans for amalgamation.

(4) That component societies again be urged to invite local qualified practicing D.O.s to attend educational activities at local, regional, and state levels.

(5) That this Committee on Medicine and Osteopathy be permitted to continue its study, and that its joint makeup be maintained, with representatives of the House, The Council, and members-at-large, appointed by the President.

Your Committee has reason to believe that a great majority of D.O.s and M.D.s are in wholehearted agreement with the studies and goals of this Committee. Continued research and intensive informational activities are necessary if our Society is to properly resolve the problem before us.

THE REFERENCE COMMITTEE on Reports of Standing Committees, John R. Pedden, M.D., Chairman, noted with approval that the report read by Doctor Coury at this House of Delegates session complements and strengthens the Annual Report. The Reference Committee urged the continuation of the present Committee's work.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MENTAL HEALTH

Benjamin Jeffries, M.D., *Chairman*

The MSMS Mental Health Committee reports 1964-1965 as being one of its busiest and most productive years. Five meetings of the Committee were conducted as the group carried out its function of studying mental health and mental illness in Michigan and making recommendations to increase the awareness and understanding of this broad health problem by both the medical profession and interested segments of the public.

Chief among the Committee's accomplishments has been the commencement of a new MSMS publication, "A.I.D.," designed to provide advice, information, and data on mental health to those involved in the community mental health program in Michigan. A trial issue of this bulletin was furnished to nearly 400 Michigan mental health leaders just prior to the 1964 House of Delegates session and subsequently the MSMS Council authorized issuance, on a quarterly basis, of four more issues during calendar 1965. "A.I.D." contains both information of a general nature and a special section prepared specifically for professional readership and dealing with technical information on hospital admission or commitment, psychiatric emergencies, aftercare, etc.

The Committee's further stated responsibility is to serve in a liaison capacity with both State and national mental health efforts. The Chairman and other Committee members have maintained such liaison through attendance at national meetings and serving as representatives on both governmental and private boards, agencies and commissions. Close contact has been maintained with the Michigan Department of Mental Health, and all pending mental health legislation has been reviewed by the Committee in its capacity as consulting and advisory group for the MSMS Legal Affairs Committee.

During 1965 over 1,000 copies of the official proceedings of the 1964 MSMS-sponsored Congress on Mental Health were distributed throughout Michigan.

Upon recommendation of the Committee, The MSMS Council authorized membership of the Michigan State Medical Society in the Michigan Mental Health Assembly so as to increase liaison with all State groups involved in the areas of mental illness and mental retardation.

Several members of the Committee, who are also charged with responsibilities by the Michigan Society of Psychiatry and Neurology, are engaged in consultation with Michigan Hospital Service and Michigan Medical Service with regard to the implementing of provisions of collective bargaining contracts which include psychiatric and related services and the Committee is regularly reporting developments to both the MSMS Council and Legal Affairs Committee.

Finally, upon recommendation of the Committee based upon observation of the activities of the Michigan Department of Mental Health subsequent to the appointment of a full-time Medical Director, the MSMS Council has expressed its view that this Department, upon the executive reorganization of state government, should be a separate principal department and not co-mingled with any other major health agency.

THE REFERENCE COMMITTEE on Reports of Standing Committees, John R. Pedden, M.D., Chairman, recommended acceptance of this report and expressed its appreciation for an excellent report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON OCCUPATIONAL HEALTH

E. A. Irvin, M.D., *Chairman*

Two Committee meetings were held. The following are highlights of these meetings.

A report was presented to the Committee of available plans for prepaid dental care.

Articles on Occupational Health were prepared for publication in *Michigan Medicine.*

A sub-committee gave a preliminary report on its study of how to detect mental disturbances in prospective employees.

A report was made to the Committee by the Legal Counsel of the Michigan State Medical Society on the "Legal Implications of Administration of First Aid in Small Plants."

This was distributed to the Health Insurance Council and the Michigan State Nurses Association. It will be considered for publication in *Michigan Medicine.*

A sub-committee reported on the legal authority delegated to the Michigan Department of Health and the Michigan Department of Labor in surveying and enforcing the rendering of first aid to employees of industry.

The Committee reviewed at length the provisions of the Workmen's Compensation Law, enacted in the spring session of the 1965 Michigan Legislature. Concern was expressed because of the unfavorable situation anticipated as a result of the passage of this bill. The Committee urges The Council to consult with the Occupational Health Committee prior to taking a stand on future legislative issues which affect industry-employee relations.

THE REFERENCE COMMITTEE on Reports of Standing Committees, John R. Pedden, M.D., Chairman, recommended acceptance of this report with the suggestion that the Committee on Occupational Health be authorized by The Council to have a common member or members with the Legal Affairs Committee to facilitate further understanding of No. 7 in the Committee's Annual Report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

H. A. Towsley, M.D., *Chairman*

During the current year, the Committee on Postgraduate Medical Education had three meetings, August 6, December 3, 1964, and June 10, 1965. At these meetings, attendance records were reviewed, subjects for presentation in regional centers were suggested, and the character of the programs to be presented in the 21 centers were discussed.

Since The Council had discontinued the Michigan Clinical Institute in 1965, the Committee decided to attempt to expand its postgraduate activities in certain centers through providing half-day clinical sessions and evening discussions to compensate for the omission of the Clinical Institute. These clinical conferences were held in the spring of 1965 at Port Huron, Marquette, Kalamazoo, and Midland. There is unanimous agreement in reports from the centers and from the participating faculty that these programs were highly successful. In view of this experience, it is sincerely hoped that the Clinical Conference-type program can be extended to other centers throughout the coming years.

A small measure of success in the spring 1965 program is indicated by comparing the attendance figures with those for the spring of 1964. In the spring of 1964, a total of 489 members attended the programs in the 18 centers of a potential of 1,234 actual county society members, or 39.5 per cent of the physicians. In the spring of 1965 there were 689 in attendance in 20 centers with a potential membership of 1,454, or 47.4 per cent. The number of 1,234 compared to 1,454 physicians is due to the fact that Kalamazoo County was added in the spring of 1965, accounting for an additional 220 members. It should be noted that 47.4 per cent of the total membership of these component county societies where programs were provided in the spring of 1965 took advantage of the continuing educational opportunities available to them, compared to 39.5 per cent in the spring of 1964.

Registration records for 1964-65 show that 906 individual physicians attended either or both the spring and fall programs in the 21 centers. This represents 60 per cent of the potential number of physicians in these county societies.

Other factors contributed to the improved attendance figures, in particular, the activities of Mr. Herbert Auer in publicizing the postgraduate programs at the local levels.

The physicians who participated in the program were: Drs. F. A. Arcari, Carl E. Badgley, Jaroslav M. Bandera, William H. Beierwaltes, Richard J. Bing, Muir Clapper, Arthur C. Curtis, Marion S. DeWeese, David G. Dickinson, Reed O. Dingman, Stefan S. Fajans, Ralph L. Fitts, F. Bruce Fralick, John R. G. Gosling, E. S. Gurdjian, E. Richard Harrell, Jr., Sibley W. Hoobler, William N. Hubbard, Jr., Richard D. Judge, A. Martin Lerner, George W. Morley, Reed M. Nesbit, Anthony C. Nolke, Gerald A. O'Connor, Edwin P. Peterson, James M. Pierce, Jr., Kenneth Pitts, Lawrence Power, William D. Robinson, Melvin L. Selzer, John M. Sheldon, William S. Smith, William R. Solomon, William B. Taylor, Harry A. Towsley, Jeremiah G. Turcotte, Arthur J. Vander, J. Robert Willson, James L. Wilson, Earl F. Wolfman, Walter P. Work.

Center	Attendance			Physicians registered for one or both meetings 1964-65	Membership—County Medical Society	
	Fall 1964	Spring 1964	Spring 1965		Potential number	% attendance of members 1964-65
Alpena	22	18	16	27	31	87%
Battle Creek	49	37	44	73	144	50
Cadillac	—	23	27	27	19	142
Grayling	13	14	13	18	29	60
Jackson	45	47	52	73	111	66
Kalamazoo	—	—	64	64	220*	30
Lansing	51	29	102	128	282	46
Midland	70	61	68	74	52	142
Muskegon	70	63	63	80	130	60
Niles	28	27	60	75	98	77
Petoskey	33	22	18	34	55	60
Port Huron	—	29	38	38	77	50
Traverse City	31	—	—	31	76*	40
Upper Peninsula						
Escanaba	17	16	15	17	26	96
Manistique	8	—	6	8	—	—
Houghton	14	13	17	22	24	91
Iron Mountain	20	8	16	20	24	83
Ironwood	12	11	12	14	12	116
Marquette	35	32	20	37	56	66
Menominee	18	23	22	23	15	153
Sault Ste. Marie	21	16	16	23	23	100
	557	489	689	906		

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1. Spring 1964. 489 physicians attending. Represents 39.5% of 1234 physicians in 18 centers.
2. Spring 1965. 689 physicians attending. Represents 47.4% of 1454 physicians in 20 centers.
3. Fall and Spring enrollment current year. 906 individual physicians attending. Represents 60% of medical doctors residing in 21 centers where programs were provided.

During the year the following subjects were presented on this program:

Fall

- Advances in the Recognition of Spontaneous Hypoglycemia
- Current Problems of Transplantation of Organs
- Diagnostic Problems in Trauma of the Extremities
- Management of Head Injuries
- Mechanisms of Micturition
- Medical Diseases and Pregnancy
- Modern Trends in Immunization
- Recent Advances in Endocrinology
- Renal Physiology
- Some Aspects of Geriatric Medicine
- The Painful Foot
- The Recognition and Management of Depression
- The Treatment of Bacterial Pneumonias

Spring

- Alcoholism and Fatal Traffic Accidents; Study in Futility
- Alcoholism; Diagnostic Difficulties
- Alcoholism; Diagnosis and Long-Range Treatment
- Arthritis
- Cardiovascular Problems in Pregnancy
- Causes and Prevention of Acute Renal Failure
- Current Anti-fungal Agents
- Current Concepts of Malignancy in the Female Reproductive Tract
- Current Problems of Transplantation of Organs
- Diagnosis and Treatment of Thyroid Disorders
- Functional Uterine Bleeding
- Management of the Ulcerative Colitis Patient
- Parotid Gland Tumors
- Office Gynecology
- Present Day Use of Respirators
- Pulmonary Emphysema
- Respiratory Distress Problems
- Rheumatic Diseases in Childhood
- Some Unsolved Problems in the Management of Hypertension
- Surgical Problems in the Gastroesophageal Area

University of Michigan Intramural Courses	Attendance
Allergy	55
Anatomy	25
Basic Sciences and Their Clinical Correlation	347
Blood Coagulation Assay Techniques	6
Cardiac Resuscitation (closed chest)	15
Dermatology	36
Diseases of the Blood	23
Diseases of the Heart	32
Electrocradiographic Diagnosis	33
Electrocardiography and Heart Disease	17
Electromyography, Clinical	26
Endocrinology & Metabolism	38
Infertility & Endocrinology	50
Internal Medicine, Clinical	41
Internal Medicine, Clinical at Wayne County General Hospital	98
Internal Medicine, Selected Clinical Topics in	9
Interns and Residents	409
Neurology, Clinical	26
Nuclear Medicine	42
Nuclear Medicine Laboratory	7
Obstetrics & Gynecology	73
Ophthalmology Conference	165
Otorhinolaryngology Conference	25
Otorhinolaryngology for Generalists	52
Pathology, Surgical Slides	22
Pediatrics	32
Physiology	26
Psychiatry	11
Psychiatry for Pediatricians	8
Pulmonary Diseases	23
Radiology, Diagnostic	30
Renal Disease, Hypertension, & Vascular Disease	36
Rheumatology	14
Therapeutics	57
Gastroenterology (A. C. P.)	102
Merck, Sharp & Dohme Conference (Cancer, Some Basic Aspects of)	339
	2337

The recommendation of the Committee to increase the honoraria for speakers on the postgraduate program in order to obtain a wide coverage of speakers was approved by The Council of the Society.

The Michigan State University has been added as a co-sponsor of MSMS postgraduate extramural programs, and Dr. Andrew D. Hunt, Dean of the College of Human Medicine, was appointed a member of the Committee.

The Committee is especially grateful to the physicians who have participated in the teaching program. The joint effort of the Medical Schools of the State to provide teachers for this program throughout the State has been an outstanding record of cooperation and achievement.

Forty-one faculty members representing the two medical schools in Michigan took on this added responsibility for the continuing education of physicians throughout the State. Of this number, one was a dean, twelve were professors and chairmen of departments, nine were professors, nine were associate professors, four were assistant professors and six were instructors.

The members of the Committee, advisors, and guests at the meetings have been most helpful in reviewing the programs and making suggestions which they feel may be of interest to practicing physicians who attend. This active interest is greatly needed and much appreciated.

The cooperation of the Michigan Department of Health, the Wayne State University College of Medicine and the University of Michigan Medical Center with the Michigan State Medical Society makes possible this program. The Committee again wishes to commend these organizations for their interest and support in the past, and express the hope for further expansion of the program in the future.

As chairman of the Postgraduate Committee, I would like particularly to commend the physicians in Marquette, Kalamazoo, Midland and Port Huron for preparing in advance brief case summaries of the patients which they were presenting at the Clinic Conferences. The preparation of such summaries aided immeasurably in increasing the educational value of the discussions presented. It is sincerely hoped that Clinic Days can be continued and expanded to other Centers. These are, by far the most satisfactory vehicle of continuing education for the practicing physician yet devised.

THE REFERENCE COMMITTEE on Reports of Standing Committees, John R. Pedden, M.D., Chairman, recommended acceptance of this report and expressed its commendation for a job well done.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON PROFESSIONAL INSURANCE PLANS

Fredrick Weissman, M.D., *Chairman*

Resolution No. 39 of the 1964 House of Delegates. This Resolution involving the study of medical-legal (professional liability) insurance in Michigan was referred to this committee by The Council for implementation.

Based upon meetings with officials of the Michigan Department of Insurance and the results of the MSMS Professional Liability Insurance Survey, this Committee has concluded that:

(1) Professional liability insurance coverage is widely available to Michigan physicians.

(2) The type of medical practice determines premium classification. Physicians doing surgery in their specialty typically carry limits of $100,000/$300,000 with an annual premium of between $200 and $300. Physicians in non-surgical fields carry typical limits of $50,000/ $150,000 with an annual premium of less than $100.

(3) The frequency of malpractice claims and suits in Michigan has shown a very significant increase in recent years, which has necessitated premium increases. One carrier reports that malpractice claims and suits have more than doubled in the last five years.

(4) A problem did exist last fall in the Detroit area with a particular agent, who when soliciting doctors, used pressure tactics by insisting that the physician carry other types of insurance, or his professional liability coverage would be jeopardized. The Committee has been advised by the MSMS Legal Counsel that this problem no longer exists.

(5) The feasibility and desirability of MSMS establishing its own professional liability insurance company is under active study by the committee. The establishment of such a company has been successful in Colorado, and the committee has been in contact with officials of the Colorado Medical Society to learn more about how their plan operates. The results of our investigations, along with appropriate recommendations will be presented to The Council as soon as they are completed.

Group Special Accident Insurance. Announcements of this new special form of accidental death and dismemberment insurance program, as developed by the Committee and adopted by The Council, were made to all MSMS members. Coverage became effective for those approved applicants on December 1, 1964.

Professional Overhead Expense Disability Insurance. The Council approved the recommendation of this Committee that it adopt a program of Professional Overhead Insurance coverage for MSMS members, as worked out by the Committee and the Provident Life and Accident Insurance Company. Announcements of this new insurance program have been made to all MSMS members. Coverage became effective for those approved applicants on July 15, 1965.

Major Medical Insurance. The Committee was not able to recommend to The Council a program of major medical insurance which made allowances for professional courtesy. A detailed analysis of all proposals submitted indicated that there is no realistic premium difference between those major medical programs which exclude, and those which include, physician services.

Brochure on Insurance for MSMS Members. A brochure, explaining the MSMS Group Insurance program, plus insurance coverages which should be considered by the physician, is being prepared by the Committee and the MSMS Insurance Advisor, Mr. Ben P. Stratton. This brochure will be presented to The Council for approval upon its completion.

THE REFERENCE COMMITTEE on Reports of Standing Committees, John R. Pedden, M.D., Chairman, recommended acceptance of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON PUBLIC HEALTH

O. D. Stryker, M.D., *Chairman*

The MSMS Public Health Committee has undergone a major revision in its composition during the past year. Formerly, this committee was composed of the chairmen of no less than fourteen specific MSMS committees, most of which themselves had highly complex and important spheres of activity. This arrangement was judged to be unwieldy and unrealistic by the 1963 House of Delegates; during the 1963-64 Society year the MSMS President appointed an interim Public Health Committee on a trial basis, composed of personnel more specifically oriented to preventive medicine but primarily engaged in private practice. This experiment proved profitable and the 1964 House of Delegates amended the MSMS Bylaws to provide officially for a Public Health Committee composed of not less than three-quarters private practicing physicians, and the State Health Commissioner or his authorized representatives.

Two meetings of the newly constituted committee have been held during the Society year 1964-1965. At each meeting the State Health Commissioner reported at length upon the current programs being planned or undertaken by the Michigan Department of Health, and information thus obtained was, where appropriate, channeled to the MSMS journal for dissemination to the physicians of Michigan.

The Committee has urged establishment by Michigan's medical schools of a full-time Chair of Preventive Medicine and Public Health and this recommendation has been concurred in by the MSMS Council. It also recommended legislative action, if necessary, to see to it that the chief executive of both the Public Health and the Mental Health departments of state government be qualified doctors of medicine and The Council also supported this recommendation. Thirdly, the committee obtained Council concurrence with its recommendation that all MSMS component county medical societies take steps to assume more positive leadership roles in attacking the problems of environmental health in their communities.

The major matter assigned to the committee, however, was the referral to the committee of the substitute for Resolutions Nos. 10 and 17 of the 1964 House of Delegates, which in essence called for the development by MSMS of a "precise definition" of the proper role of public health departments. This substitute resolution was adopted by the 1964 House as an expression of less-than-complete concurrence with the tenor of the 1962 AMA statement regarding public health, including the amplification of that statement later made by the AMA Board of Trustees.

The committee noted that it had been specifically requested to deal with the definition of departments of public health and their role, whereas the AMA had addressed itself to the term "public health" and had, as a consequence, issued a statement embracing a wide sphere of health activity including both public and private programs. It seemed to the committee, therefore, that it should attempt to draw a recognizable line of demarcation between "public health" per se and Departments of Public Health.

Accordingly, and in accordance with the substitute resolution calling for the development of a "precise definition" to be referred to the 1965 House of Delegates, the committee, on July 22, 1965, recommended the following definition to The Council, MSMS:

"Public health is an all-encompassing term in the sense that all of medicine exists to improve the health of the public. A Public Health Department is a legal entity, required by Michigan statute. Its powers, duties, and functions should be those vested in it by State statutes and by the community for the maintenance and protection of the health of the people of the community it serves.

"It should coordinate and cooperate with the efforts of medical societies, voluntary health associations, and other health-oriented groups in promoting efforts to improve the health of the people.

"It is the responsibility of the organized medical profession to assume an important leadership role in such efforts. State and county medical societies, and Departments of Public Health, should cooperate in the interest of community health and should always keep in mind the need for a proper balance between local public health programs and the private practice of medicine."

On July 22, however, The MSMS Council approved the recommendation of its reference committee which reviewed the foregoing definition that the definition lacked the requested and desirable precision. The definition was disapproved by The Council.

During its deliberations on the definition of the proper role of public health departments, the committee received the viewpoints of some component county societies. The committee, however, had hoped that it would be utilized by all components as a resource when public health questions arise; in the future, the committee trusts that county societies will direct public health questions to it so that it may better serve The Council and membership of MSMS.

THE REFERENCE COMMITTEE on Reports of Standing Committees, John R. Pedden, M.D., Chairman, recommended acceptance of this report, noting that the assigned job of defining public health had not been completed.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON PUBLIC RELATIONS

R. W. Teed, M.D., *Chairman*

The Public Relations Committee once again faced squarely up to the responsibility to make physicians better understood by their patients, para-medical personnel, legislators, newsmen, other professional associates, educators, and the general public.

This cannot be done alone by a Committee but must be a team effort by MSMS officers, members of The Council, delegates to the MSMS House of Delegates, officers of the component county medical societies, MSMS staff members—and in reality by each member of the medical profession.

The Public Relations program of MSMS includes both the projects recommended specifically by the PR Committee and those carried out more directly by the staff under the direction of The Council. Many of the latter projects really were recommended by the House of Delegates and other MSMS committees.

Seldom can an MSMS project which concerns a special audience or the general public be carried out by any MSMS committee without some public relations flavor to the project. Some of the following comments therefore, may be covered by some other MSMS committee with a different reflection.

Before we enumerate the (1) PR Projects which Reached the General Public and (2) PR Projects which Reached Special Audiences, we should briefly discuss the many hours spent already to plan the "MSMS Centennial Session" and the following MSMS Centennial year activities during 1965-66.

While the PR Committee has not been directly concerned with the Centennial planning, we are in a position to point out its potential values. While it will do much to unite the medical profession in greater public service projects, the Centennial Session with its effective designation of special days will create much in the way of news. The awards, the speakers, the special projects, et al., will provide unlimited opportunities for MSMS Officers, The Council, The House of Delegates, the Sections and the Committees to review a century of service in medicine. And hand in hand, it provides new chances to chart the course for a second hundred years of even greater service to the public.

The PR Committee is eager to assist the county medical societies to carry out special Centennial year activities. While this report reviews the past year, the upcoming year of 1965-66 undoubtedly offers the greatest opportunities ever for Michigan medicine to tell its story.

PR Projects Which Reached the General Public

While some MSMS projects are directed at specific audiences, many of the activities are much more broadside in their operation. Often MSMS seeks to impart information, to influence decisions or to inspire better health. Following are some of the MSMS programs which did affect the general public in a desired way.

Measles Vaccinations Campaign. During the spring, MSMS conducted an ambitious Measles Educational Campaign. The number of children vaccinated during February and March, for example, shot up to 100,000 far above the usual 10,000 per month. Thanks to a financial grant from Merck Sharp and Dohme, the campaign included billboards, radio and television, newspaper stories, photos and editorials, etc. This was one of the most comprehensive preventive medicine efforts of MSMS in recent years.

Eldercare vs. Medicare. The MSMS efforts to inform the public about the Eldercare proposal of the AMA and to point out the shortcomings of the Administration's Medicare proposal had many public relations ramifications. In cooperation with the American Medical Association, educational ads were placed in each of the 362 daily and weekly papers in Michigan, and special messages were carried by virtually every radio and television station. MSMS spokesmen appeared before numerous meetings of state-wide organizations and local groups. During the peak of the effort in the spring, 244,568 pieces of literature were sent to Michigan physicians for distribution to their friends and patients. A sincere effort was made to carry out this informational activity in a positive manner, showing MSMS interest in providing the best possible care for the aging under the most feasible financing approach.

Community Health Week. The AMA is a good judge of public relations projects across the nation—and the AMA rated the 1964 Community Health Week in Michigan as "one of the most comprehensive programs . . . carried out on a carefully-coordinated state-wide basis in communities throughout Michigan." Supplementing the fine local efforts by the county medical societies, MSMS worked hand in hand with the Michigan Health Council and the Michigan Association of the Professions on state-wide projects. A wide variety of community projects were carried out with specific goals, all complemented by news and promotional efforts of the MSMS staff.

Television Programming. Michigan residents have a far greater understanding of their physicians and medical matters, thanks to the two weekly television programs officially produced by the Michigan Association of the Professions. Often physicians appear to explain the art and science of medicine. WJBK-TV in Detroit each week presented "Decisions, The Moment of Truth," a 15-minute program cosponsored by the Michigan Health Council and the Michigan Association of the Professions; and WJIM-TV in Lansing each week aired "Formula," a half-hour MAP show on prime time. An estimated 250,000 viewed the continuing programs each week.

Newspapers. Readership surveys always rate health news very high, so MSMS issued well-written, timely news releases throughout the year to the daily and weekly newspapers in Michigan. Never seeking to overburden newspapermen with trivia, MSMS nonetheless sent more news material out this past year than in years previous.

Newspaper clippings prove that important health advice and MSMS policy statements are reaching the public. (See comments below about a Medical News Conference).

MSMS Radio Series. The bulk of the weekly radio programs which feature MSMS members dealt with preventive medicine. The results were difficult to measure, but surely this is one of the obligations that MSMS must fulfill with vigor. Each week, the MSMS Committee on Scientific Radio and Television arranged for authoritative physicians to discuss various diseases, illnesses, and other projects. Produced by the University of Michigan, the tapes then are sent by WUOM to 38 stations in Michigan, Ohio and Canada.

Distribution of Pamphlets. MSMS members have little concept of the large volume of health pamphlets that are distributed each year by the Society. Thousands are sent out in response to requests received through the daily mails for general information about cancer, mental health, colds, rheumatic fever, etc.

MSMS also deliberately takes advantage of many statewide conventions, such as the Michigan PTA and the Michigan Adult Education Association, to distribute materials which will both be helpful to the health of the general public and also advantageous to the public relations of physicians.

Motion Pictures. Films were distributed by MSMS to schools, youth groups, farm organizations, civic clubs, PTA meetings, etc., on a variety of health subjects. Many of these films were made available by the AMA, Michigan Health Council and other sources. The new AMA film, "Medicine and Religion," was booked frequently across the state, as a popular new addition to the MSMS Public Relations Library Service. A special MSMS Centennial film is being produced for use throughout the 1965-66 Centennial year.

Speakers. Once again it was the "Medicare" issue which gave MSMS the opportunity to provide speakers for many state-wide meetings. County medical societies took the leadership in providing able speakers for the local meetings of luncheon clubs, business groups, women's organizations, etc. Many medical subjects also were covered by MSMS officers, committee chairmen and others who were willing to contribute their skills in this important form of public relations.

PR Projects which Reached Special Audiences

While many MSMS activities seek to reach the total public, many others have a more limited, specialized audience. This is proper, as MSMS must often sharp-shoot a specific group with specific purposes. The following examples illustrate this point effectively:

Michigan Newspapers. For the first time in five years, MSMS sponsored a Medical Writers Conference at Michigan State University, under the co-sponsorship of the MSU School of Journalism, MSU College of Human Medicine, and the Michigan Tuberculosis and Respiratory Disease Association. A showcase for physicians, the conference helped to improve understandings on the part of both doctors and newspapermen. Representatives participated from most of the larger Michigan dailies and several of the influential weeklies.

Liaison with County Medical Societies. MSMS liaison with its component county medical societies was improved and expanded this past year. Much of this work is done by the MSMS District Councilor with the county societies in his own geographic area. To increase MSMS contact with the county societies, especially for community projects, one of the MSMS staff members was reassigned to become the traveling representative from MSMS to the county societies. All other staff members also continue to serve in a liaison capacity with several county organizations.

MSMS Officers Conference. The MSMS Public Relations Committee shared in the planning and execution of the annual Officers Conference in Grand Rapids. Formerly known as the County Secretaries Public Relations Seminar, the Conference appropriately this year dealt with the Centennial to a large degree. One of the new features was an attractive public relations display of how-to-do-it materials.

Liaison with "The Gals." Perhaps more than ever before, the Woman's Auxiliary to MSMS and the Michigan State Medical Assistants Society complemented the work of MSMS especially in the legislative area. MSMS is always pleased to be able to assist these two groups as they do yeoman work in career recruitment, continuing education, community service, etc.

Inter-Professional Liaison. The Michigan Association of the Professions, fostered at its inception by The Council, continues to provide many avenues for better understanding and joint action. MSMS members continue to serve as officers, on the board of directors, on committees and in responsible positions each year at the Annual Congress of the Professions. The MSMS delegates to the AMA Convention in New York successfully introduced a resolution which "encouraged other state societies to take a leadership role in the formation of Associations of the Professions in other states."

The Michigan Health Council continues its fine performance as doctors of medicine work with other health professionals in many ways, such as health career recruitment, preventive health care, nursing home care, etc. The Michigan Health Council MD Placement Service is of untold value to the medical profession—and the citizens of Michigan.

Career Recruitment With Students. Career recruitment continues to be a constant, year-round effort of MSMS. Michigan needs to interest qualified young people in entering the health profession, and MSMS also needs to constantly convince the public that medicine is not a "closed profession." MSMS arranged for many speakers for career-day programs, provided give-away folders about medicine and the paramedical fields, and scheduled films from the MSMS Public Relations film library.

Liaison With Michigan Legislators. A practice which is good both from public relations and legislative standpoints—conferences in Lansing between physicians and their legislators—was continued. Quite a large percentage of the county medical societies were involved in sending their leaders to the Capitol City to have a dinner meeting at the MSMS headquarters building with their state representatives and senators. The conferences greatly increased understandings between the MSMS members and their local legislators.

Once again, MSMS provided a First Aid Station at the Capitol Building in Lansing, to serve the Michigan Legislators while they are away from the care of their own hometown physician. The Legislators genuinely appreciate this service.

Liaison With Congressmen. Another project that legitimately is reported both under Public Relations and Legislative is the annual visit by MSMS officials to Washington. Led by the MSMS President, the men explain medicine's point of view on legislative issues to the Congressmen and Senators from Michigan, and work closely also with the legislative aides.

Community Mental Health Newsletter. In one of the new public relations efforts during the year, the MSMS Mental Health Committee published a newsletter, appropriately called "AID." It was written primarily for the non-medical members of the new community mental health board appointed in each of the counties. Copies were sent also to other interested lay persons and to physicians with a special interest in mental health.

Liaison With The Clergy. A new, special audience for MSMS this past year was the clergy. Encouraged by the MSMS Committee on Medicine and Religion, many county medical societies held special programs, with audiences of physicians and doctors ranging up to 500. Twenty-eight county medical societies have established Medicine and Religion Committees to work toward even more effective health care of "the whole man." Earnest dialogue has replaced a nodding to one another between doctors and ministers in hospital corridors.

In closing this report, the Committee again wishes to stress that good public relations must be earned and maintained. The respect that the Michigan State Medical Society and the medical profession as a whole receives depends greatly upon the individual doctor in his office, in the hospital and in his community.

The Public Relations Committee is eager to receive ideas from MSMS members and shall be ever alert to improve present ongoing projects and to initiate new meaningful programs.

THE REFERENCE COMMITTEE on Reports of Standing Committees, John R. Pedden, M.D., Chairman, recommended acceptance of this report, commended the Committee for an excellent job and recommended its continuation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON RESPIRATORY DISEASES

R. A. Rasmussen, M.D., *Chairman*

The Committee on Respiratory Diseases respectfully recommends that the following be the "Purposes" of the Committee:

"The Committee shall establish communication with all organizations and agencies which develop information on respiratory diseases for the enlightenment of the medical profession and the public. It shall assist in the distribution of these acceptable materials, and it shall advise these organizations and agencies on timely approaches to the various aspects of respiratory disease control. It may develop associated similar supplemental programs through the Michigan State Medical Society."

In addition, the Committee recommends that the following be the program of the Committee on Respiratory Diseases:

"That the programs of related organizations (those involved in respiratory diseases) be explored, reviewed, and examined by this Committee; and that the Chairman be authorized to request these groups to supply this information in writing; and, after review of this material by the Committee, some of the groups be invited to send a representative to a joint meeting so as to obtain further information on acceptable projects."

Lastly, that starting in the autumn of 1965, the initial program of the Committee be directed toward the following diseases: pulmonary emphysema, chronic bronchitis and carcinoma of the lung and respiratory tract including possible causative agents such as the cigarette, tuberculosis, the pneumoconioses, and other respiratory conditions leading to pulmonary insufficiency or pathology.

THE REFERENCE COMMITTEE on Reports of Standing Committees, John R. Pedden, M.D., Chairman, recommended acceptance of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON RURAL MEDICAL SERVICE

Robert E. Rice, M.D., *Chairman*

A meeting was held on December 14, 1964, at the MSMS headquarters building. The main topic of consideration was a prospectorship plan, presented by R. W. Spalding, M.D., of Allegan. Essentially this plan was concerned with doctors in training serving in small community hospitals in order to better acquaint them with the problems and advantages of small-community practices. Realizing that implementation of this would require the involvement of the medical schools, a meeting with representatives of the medical schools was set up.

On February 10, 1965, the Committee met with Harry Towsley, M.D., Associate Director of Postgraduate Medicine, University of Michigan Medical School. A representative from Wayne State University was unable to attend. Dr. Spalding, in conjunction with the administrator of the Allegan Health Center presented their prospectorship concept. Dr. Towsley presented a detailed account of the plans of the University of Michigan Medical School for implementation of a Family Practice Program starting at the medical school. In addition to some changes in curricula arrangements, provision was made for spending some time in one of four selected community hospitals under the supervision of the medical school. Dr. Towsley did not feel that the "Allegan Plan" could be included at this time. The Committee was, of course, pleased to learn of the Family Practice Program. However, it was felt that the "Allegan Plan" might have some additional merit because it involved hospitals smaller than those included in the Family Practice Program. Interest in this aspect of the matter will be maintained for the future.

The Chairman attended the 18th Rural Health Conference in Miami in March of 1965 and submitted a report of the conference to The Council.

A Health Career Day was held in Cadillac under the auspices of the Michigan Health Council. The Chairman attended this as a member of a panel. In addition to the presentations of John Doherty of the Michigan Health Council and Norman Davis of the Sears-Roebuck Foundation, the Chairman discussed how a young doctor might look at a small community in deciding whether he would choose to practice in this locale.

The Chairman supplied an editorial for the July issue of *Michigan Medicine* entitled "Doctors Wanted for Small Towns", which dealt with suggestions for individual physicians and county medical societies in promoting interest in attracting young physicians to practice in small communities.

The committee is compiling and taking notice of activities that are being carried on in other states in relation to this problem of a decreasing supply of physicians for small community practices.

THE REFERENCE COMMITTEE on Reports of Standing Committees, John R. Pedden, M.D., Chairman, recommended acceptance of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON SCIENTIFIC RADIO AND TELEVISION

G. H. Lowrey, M.D., *Chairman*

During the previous 12-month period, two meetings of the Scientific Radio and Television Committee were held. The following information is submitted concerning major activities by this Committee.

1. The fifteen minute program "Prescription for Health," jointly sponsored by MSMS and the University of Michigan, was carried on a regular basis during the current year by a total of 30 stations within the State of Michigan. In addition, it is carried by two stations in Ohio and one in California.
2. Carrying out a Council-approved committee recommendation, a five-minute health program entitled "Medical Talk" was initiated in November, 1964. To date, 15 Michigan stations and one Ohio station carry this new program on a regular basis.
   Both programs are available to subscriber stations on a 52-week basis. A majority of the stations carry the program year-round, while the remainder broadcast the programs for a September-June period.
3. In planning programs for 1965-66, it was determined that
   A. A series of programs on the Centennial should be presented, which would include (1) a history of medicine in Michigan, and (2) publicize activities for the Centennial Year which are open to the public.
   B. The MSMS Socio-Economic Committee be asked to prepare and record a series of programs based on (1) the material in the 1964 Medical Society publication, "Governmental Health Care Assistance

Programs in Michigan," and (2) "Why Medical Care and Hospital Care Costs Continue to Rise."

4. As a result of a recommendation that physician participation in the two radio programs be expanded to include a larger number of doctors, it was determined that more physicians from the Detroit-Ann Arbor area should be appointed to the Committee, and that Committee members from the Washtenaw County area be asked to assume the responsibility of assisting the Chairman in recruiting additional physician participants.
5. A representative from the University of Michigan radio station (which records and distributes both programs) reported that information gleaned from a recent questionnaire indicated that subscriber stations were, for the most part, broadcasting "Medical Talk" in highy desirable time slots. The University Station interprets this as an indication that the program is well thought of.

THE REFERENCE COMMITTEE on Reports of Standing Committees, John R. Pedden, M.D., recommended acceptance of this report.

THE HOUSE adopted the report of the Reference Committee.

16. Reports of House of Delegates Committees

CENTENNIAL ADVISORY COMMITTEE

L. F. Hayes, M.D., *Chairman*

The Committee met twice during this past year.

The preliminary program, presented to and approved by the House of Delegates last year was reconsidered. The general recommendations were again approved and details regarding special events, award ceremonies and special speakers were discussed.

A final agenda for the House of Delegates Centennial Observance, independent of the normal business of the House, was drawn up; a list of desired speakers was made. This report was forwarded to the Centennial Committee and the MSMS staff for their guidance in their overall preparations for the Centennial Session.

The Chairman thanks the members of the Committee for their work and advice.

THE REFERENCE COMMITTEE on Reports of Special Committees, D. N. Sweeny, Jr., M.D., Chairman, reported "This exceptional Centennial Session of the Michigan State Medical Society and its House of Delegates reflects the many hours of thoughtful planning of this Advisory Committee. We thank them for their efforts and commend them for the results."

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON CONSTITUTION AND BYLAWS

H. Maxwell Golden, M.D., *Chairman*

The Committee conducted two meetings during the past year, on April 21 and August 25. To fulfill its obligation to conduct an intensive study of Section 8 (h), Chapter 9 of the MSMS Bylaws (sections - criterion), two extensive surveys of all existing MSMS Sections and other specialty groups were conducted and analyzed.

After careful deliberation, the Committee recommends the following actions to the 1965 House of Delegates:

(1) Regarding Affiliate Membership

that the House amend Article VIII of the MSMS Constitution, adding the words "affiliate membership" to be inserted between "associate members," and "retired members" so that the section, as amended, will read as follows:

ARTICLE VIII—MEMBERS; Section 1.—CLASSIFICATION—This Society shall consist of active members, honorary members, associate members, affiliate members, retired members, non-resident members, life members, and military members, elected in accordance with the Bylaws. NOTE: Since the amendment to the Constitution must lie over for one year before it can be acted upon, the Committee is of the opinion that the Bylaws cannot be amended to implement this change until the following year. In accordance with the directions of The Council, however, the Committee has prepared proposed amendments to the Bylaws which it herewith submits as informational material, to be laid over for ultimate action if and when the constitutional amendment is adopted;
Section 8 of Chapter 2 of the Bylaws would be renumbered as Section 9, and a new Section 8 would be inserted to read as follows:

Section 8.—AFFILIATE MEMBERS—The Council may elect as an affiliate member any person who is;

(a) A physician member of a chartered national medical society of a foreign country adjacent to the United States, or
(b) An American physician, located in a foreign country or possession of the United States, and who is engaged in medical missionary or similar educational or philanthropic labors, or,
(c) A dentist who holds the degree of D.D.S. or D.M.D., and who is a member of a state or local dental society, or,
(d) A pharmacist who is a member of the American Pharmaceutical Association, or,
(e) A teacher of medicine or of a science allied to medicine who is a citizen of the United States but is not eligible to any other class of membership, or,
(f) A scientist in a science allied to medicine who is a citizen of the United States but is not eligible to any other class of membership.

Nominations for affiliate membership may be submitted to The Council by county medical societies or may be initiated by The Council. An affiliate member shall pay no dues and shall not have the right to vote or hold office. He shall have the privilege of attending scientific assemblies but shall not be entitled to receive any publication of the Society except by subscription.

(2) Regarding Sections

that the House repeal subdivision (h) of Section 8 of Chapter 9, and redesignate present subdivision (i) as (h).

that the House add new Chapter 13 to the Bylaws, renumbering present Chapter 13, 14, 15, 16 and 17 as 14, 15, 16, 17 and 18, respectively that the House adopt a new chapter of the MSMS Bylaws to read as follows:

CHAPTER 13—SECTIONS; Sec. 1.—ESTABLISHMENT—In furtherance of the scientific aims and purposes of the Society, the following sections are established:

Allergy and Applied Immunology
Anesthesiology
Dermatology
Gastroenterology
General Practice
Gynecology and Obstetrics
Internal Medicine
Neurological Surgery
Occupational Medicine
Ophthalmology and Otolaryngology
Orthopedic Surgery
Pathology
Pediatrics
Plastic Surgery
Proctology
Psychiatry and Neurology
Public Health and Preventive Medicine
Radiology
Surgery
Urology

Sec. 2.—PURPOSES—The purposes of Sections shall be

(a) to aid in the preparation and presentation of the scientific programs of the Society, and,
(b) to provide forums within the organizational structure of the Society for the study and consideration of matters of special interest or significance to members of

the various recognized specialty groups in the practice of medicine and surgery.

Sec. 3.—MEMBERSHIP—The membership of a section shall consist of the members of this Society who are members of one or more of the specialty organizations representative of the section and all other members of the Society who register as members of the section at an annual session of the Society.

Sec. 4—MEETINGS—Each section shall hold an annual meeting at the time and place of the annual session of the Society of which advance notice by mail shall be given to section members.

Sec. 5.—ELECTION OF OFFICERS AND DELEGATES—At its annual meeting each section shall elect a Chairman, a Vice-Chairman and a Secretary, each of whom shall serve for a term of one year. At the first annual meeting held by a section and thereafter at each alternate annual meeting, it shall elect a delegate and an alternate delegate to the House of Delegates of the Society, such delegate and alternate delegate to serve for terms of two years each and to have the status, when seated, of an ex-officio member of the House of Delegates as provided in Sec. 2 of Chapter 9 of these Bylaws.

(3) Regarding Councilor elections and terms of office that the House amend Section 1, Chapter 12 of the Bylaws to read as follows:

Sec. 1.—TERM OF OFFICE—Except as herein otherwise provided, officers shall take office immediately after the election. With the exception of Councilors, they shall serve until the next Annual Session and until their respective successors shall have been elected. Councilors shall serve for three years.

NOTE: At the time of the enactment of Section 1 of Chapter 12 of the Bylaws, some complicated provisions were required in order to accomplish the changeover from five years to three years of the terms of office of Councilors. This language having served its purpose and being now unnecessary, it is eliminated by the foregoing proposed amendment.

(4) Regarding membership in MSMS and component county societies

that the House amend Section 1, Chapter 2 of the Bylaws to read as follows:

Sec. 1.—ACTIVE MEMBERS—Active Members of this Society shall comprise all the active members of the several component county societies. To be eligible for active membership in any component county society, a doctor of medicine must hold an unrevoked license to practice medicine, surgery and mid-wifery in Michigan or if unlicensed, must be engaged in academic teaching, research or administration. To maintain active membership in any component county society, a doctor of medicine must maintain active membership in this Society and comply with all the provisions of the Bylaws of this Society and the component county society.

NOTE: In accordance with the recommendation of The Council, the Committee proposes this express clarifying amendment to the Bylaws to eliminate any possible misinterpretation of the requirement that any active member of a component county medical society must maintain membership in the state society.

(5) Regarding Advisory Committee of Past Presidents

At the request of the Advisory Committee to the Executive Director, the Committee has prepared an amendment to the Bylaws to expand the Standing Committee of Past Presidents to include Past Chairmen of The Council and Past Speakers of the House of Delegates.

We recommend that the House amend Section 1 (k) of Chapter 11, so that the first sentence will read as follows: "The Committee of Past Officers shall consist of all Past Presidents, Past Chairmen of The Council, and Past Speakers of the House of Delegates of the Society."

(6) Seniority, Manner of Election of AMA Delegates

The Committee, after studying the provisions of the MSMS Bylaws regarding seniority, manner of election, etc. of Delegates and Alternate Delegates to the American Medical Association, concluded that inasmuch as these provisions are to be implemented within the discretion of the Speaker of the House, no clarification by amendment would be required. However, the Committee concluded that there is implied by the present provisions the methodology that Alternate Delegate nominations should not be called for until the results of the Delegates' elections are known. Further, the Committee noted that Alternate Delegates serving thir second year shall hold seniority over Alternate Delegates serving their first year in office. It was the Committee's view that, therefore, when an Alternate Delegate is either elected or appointed to serve for the unexpired term of a Delegate who has vacated the post, such Alternate should not thereby acquire the seniority of his predecessor.

In such a contingency, the Committee's consensus was that if, for example, the first Alternate Delegate assumed the Delegate vacancy, the individual appointed or elected to replace him would serve the balance of the unexpired term but, for seniority purposes, would as the last Alternate Delegate chosen have the least seniority of all Alternates.

Finally, the Committee acknowledges with thanks the splendid contributions of MSMS Legal Counsel Lester P. Dodd as Advisor to its deliberations.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. Tupper, M.D., Chairman, recommended approval of the report with minor corrections and amendments (as printed above). The Reference Committee, in addition, noted that a constitutional amendment proposing that the name of MSMS be changed to the Michigan Medical Association had been duly laid over from the 1964 Session of the House of Delegates. The Reference Committee recommended that the proposed amendment be not adopted.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE TO STUDY MULTI-COUNTY COMPONENT MEDICAL SOCIETIES

Paul Ivkovich, M.D., *Chairman*

The 1964 MSMS House of Delegates adopted a recommendation of the MSMS Council that all component medical societies be re-chartered as a part of the Society's 100th Anniversary celebration, thus providing an appropriate opportunity for review of the composition of multi-county component societies. Subsequently, the Speaker of the House appointed this Committee to review the current structure of MSMS.

The Committee heartily concurs that it will be most fitting to re-charter the component societies during the Centennial Year, but is persuaded that newly issued charters should not be altered pending completion of its studies now underway. Although it may be deemed advisable to later recommend certain changes in the composition of the societies, the issuance of a new charter during the Centennial Year will not, it is felt, preclude changes at a future date.

It is apparent to the Committee that if the composition of the multi-county societies, which in turn affects the organization of the House of Delegates, is to be thoroughly studied by the Committee, more time will be required. What is the most efficient and productive operation of the society is of paramount importance.

Quite obviously, present-day population patterns, social, patterns, medical facilities, modes of transportation and the like are vastly different from those existing at the turn of the century, by which time the existing pattern of Society organization was largely established. In 1900, for example, the City of Detroit had less than 300,000 residents, while the State Capital was approximately the size of Escanaba today.

The Committee is convinced that medical organization should be judged by at least two basic criteria: first, is it so constituted as to best serve the members of the profession?; and second, is it structured so as to most effectively cope with the larger society in which it exists, and which it serves?

It has become apparent to the Committee in its deliberations to date that just as some extremely small county medical societies lack the members and facilities to function as an effective unit in MSMS programs, so also it is possible that extremely large county medical societies may become so unwieldy as to fail to realize their full potential for effectiveness. In either case, medical organization can fall somewhat short of best safeguarding the health interests of the public.

The Committee considers its task of reviewing the composition of multi-county component societies, and indeed reviewing the entire structure of MSMS county medical organization, to be an extremely complex one requiring additional study. The Committee rejects "change for the sake of change," and at the same time is mindful of the fact that the standards of years past may not be those to hew to in a period distinguished by constant and drastic social change.

The Committee's work is well begun. It must, however, continue for some time before thoughtful recommendations can be formulated for the consideration of the House of Delegates. Therefore, the Committee is hopeful that the House will accept its interim progress report and continue it so that it may complete its assigned task.

THE REFERENCE COMMITTEE on Reports of Special Committees, D. N. Sweeny, Jr., M.D., Chairman, recommended acceptance of the interim report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE TO STUDY PROCEDURES OF THE HOUSE OF DELEGATES

N. L. Avery, M.D., *Chairman*

The Committee necessarily devoted much of its deliberation to considering those special situations which might arise during the unique Centennial Session of 1965, when a large number of special events will have the unavoidable effect of calling for the House of Delegates to adhere to a more rigid time schedule than is customary.

It was recognized that the Speaker of the House has wide power of discretion to recommend any necessary emergency actions. The Committee considered the possibility that a large number of resolutions might be presented to the 1965 House, and that many of these might be of such a nature as to require prolonged deliberation. The Committee also noted that one of the business sessions of the House is scheduled for Cobo Hall and that two luncheons, plus other special ceremonies, may affect the meeting and reporting of reference committees.

It was determined that every effort should be made to receive all resolutions, and subsequent reference committee reports, prior to the Tuesday evening session, but that under no circumstances should the delegates' full opportunity to conduct their business be suppressed.

The Committee therefore unanimously recommended that the Speaker exercise his discretion, depending upon the volume of business before the House, to recommend such rules and order of business as will permit the House to conclude its business as scheduled during the Centennial Session or, if necessary, place before the House alternative proposals for deliberation beyond the scheduled time.

Finally, the Committee noted that each year matters have been considered by it which have resulted in recommendations for improvement of the House operation, and felt that it could contribute in the future. The Committee therefore recommends that it be continued during the 1965-66 year and that future consideration be given to changing its status from that of an Ad Hoc to a Standing Committee.

The Rules of the House were suspended for the purpose of immediate consideration of this Committee report, by the House as a Committee of Whole.

THE HOUSE adopted the report of the Committee.

RESOLUTIONS

THE REFERENCE COMMITTEE on Rules and Order of Business, S. N. Kelso, Jr., M.D., Chairman, recommended that Item 34 of the Order of Business, "Introduction of Resolutions; Other New Business" on Tuesday, September 21, at the 8:30 a.m. session, be deleted from the schedule of the House so that no new business be introduced during either the fifth or sixth meeting of the House without unanimous consent of the Delegates present, except when presented by The Council, and that all new business so introduced shall require the affirmative vote of three-fourths of the Delegates present for adoption.

THE HOUSE adopted the report of the Reference Committee because of the number of special events added to the regular schedule of the House as a part of the celebration of the Centennial of MSMS.

RESOLUTION 1

Negotiation of Fees in Governmental Health Programs
Introduced by Milton R. Weed, M.D., Wayne

Whereas, in the negotiation of fees in governmental health programs the planning on a local basis or through the various specialty societies would tend to be divisive and fragment the effects of the medical profession, therefore be it

RESOLVED: That The Council of the Michigan State Medical Society invite the Board of Directors of Michigan Medical Service to appoint three of their physician members as representatives to a joint committee of the two organizations and that this joint committee be designated as the sole negotiating agent for physicians' services in all governmental programs, and be it further

RESOLVED: That the fees negotiated by this joint committee be in accordance with the usual and customary fees as determined by the House of Delegates of the Michigan State Medical Society.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, considered Resolutions 1, 35 and 45 together.

For Reference Committee and House action, see Resolution 35.

RESOLUTION 2

State Program on Air Pollution Control
Introduced by Louis E. Heideman, M.D., Wayne

Whereas, our atmosphere is becoming increasingly polluted as a result of the release of tons of materials by industrial concerns and by individuals into our atmosphere, and

Whereas, such pollution is a serious health hazard, therefore be it

RESOLVED: That the Michigan State Medical Society recommend to the Legislature of the State of Michigan that a comprehensive program for the control of air pollution be established.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, recommended approval of the resolution as amended by the following substitute Resolved portions:

RESOLVED: That the Michigan State Medical Society commend the Legislature of the State of Michigan for the passage of Enrolled House Bill No. 2186—an Act to control air pollution in the State, to create an Air Pollution Control Commission within the State Health Department, to prescribe its powers and duties, and to provide penalties. It is also to be commended for passage of Enrolled House Bill No. 2276—an Act to provide for the exemption of air-pollution control facilities from certain taxes; and be it further

RESOLVED: That this action be spread on the minutes of

the House of Delegates and that notice of these actions be sent to each member of the Legislature of the State of Michigan.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 3

State Program on Water Pollution Control
Introduced by James C. Danforth, Jr., M.D., Wayne

Whereas, water supplies are being increasingly polluted by communities and industries to a degree which threatens the supply of potable water, therefore be it

RESOLVED: That the Michigan State Medical Society recommend to the Legislature of the State of Michigan that legal measures be taken to insure protection of the State's water supply forthwith.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, recommended adoption of this resolution amended as follows:
Whereas, water supplies are being increasingly polluted by individuals, communities and industries, to a degree which threatens the supply of potable water, therefore be it

RESOLVED: That the Michigan State Medical Society commend the Legislature of the State of Michigan for powers granted to the Water Resources Commission to permit it to protect and conserve the water resources of this State, to have control over pollution of any waters of the State and Great Lakes, with power to make rules and regulations governing the same, and to prescribe the powers and duties of such Commission; to prohibit the pollution of any waters of the State and the Great Lakes as included in Enrolled Senate Bill No. 69; and be it further

RESOLVED: That this action be spread upon the minutes of the House of Delegates, and that notice of these actions be sent to each member of the Legislature of the State of Michigan.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 4

Hiring of the Handicapped
Introduced by John G. Slevin, M.D., Wayne

Whereas, the Workmen's Compensation Laws as now written put a burden upon industries that hire handicapped workers, and

Whereas, the insurance companies that write Workmen's Compensation insurance in the State of Michigan charge higher fees for industries that hire handicapped persons, and

Whereas, many handicapped persons are therefore unable to find employment and become burdens to the state and local communities, therefore be it

RESOLVED: That the Michigan State Medical Society recommend to the State Legislature that legislation be enacted to limit the liability for pre-existing handicaps in order that the practice of hiring the handicapped would be encouraged.

THE REFERENCE COMMITTEE on Resolutions, H. M. Golden, M.D., chairman, recommended adoption of the resolution with the Resolved portion amended as follows:

RESOLVED: That the Michigan State Medical Society recommend to the State Legislature that legislation be enacted to limit the liability for pre-existing handicaps by waiver or other means in order that the practice of hiring of the handicapped would be encouraged.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 5

Area-Wide Hospital Planning
Introduced by Russell F. Fenton, M.D., Wayne

Whereas, area-wide hospital planning committees have been established throughout the country, and

Whereas, even if a hospital can provide its own funds for building, Michigan Hospital Service may deny participation to that hospital if it does not have the approval of the local hospital planning committee, and

Whereas, such discrimination hampers the physician in his proper medical care of patients, therefore be it

RESOLVED: That the Michigan State Medical Society insist that area-wide hospital planning be kept on a voluntary basis, and be it further

RESOLVED: That area-wide planning committees have adequate physician representation, and be it further

RESOLVED: That Michigan Hospital Service recognize as a participating hospital any hospital approved by the Joint Commission on Accreditation of Hospitals.

THE REFERENCE COMMITTEE on Resolutions, H. M. Golden, M.D., chairman, considered Resolutions 5 and 16 together.

For Reference Committee and House action see Resolution 16.

RESOLUTION 6

Principles for Federal Medical Programs
Introduced by Benjamin Jeffries, M.D., Wayne

Whereas, new and proposed Federal legislation makes it essential that the medical profession define its relation to government, and

Whereas, physicians by training, experience and orientation have specific knowledge, skills and experience to contribute to the planning, operation and organization of medical facilities, therefore be it

RESOLVED: That the House of Delegates to the Michigan State Medical Society reaffirm the following principles:

1. That medical facilities must be physician-oriented and directed;
2. That physicians' services be clearly differentiated and separated from hospital services;
3. That the patient's physician be free of controls and restrictions that interfere with providing the highest quality of medical care;
4. That the physician-patient relationship is the keystone to good medical practice, which means that each patient must have freedom of choice of physician and each physician freedom of choice of patient;
5. That frequency of use and criteria for medical care is, and must continue to be, the responsibility of physicians;
6. That governmental agencies must recognize their obligation to pay the usual and customary rates of compensation;
7. That governmental agencies may provide medical service and/or medical facilities only when they cannot be purchased, or are not available from private sources, and be it further

RESOLVED: That the Michigan State Medical Society, acting through its Council, implement these principles, and be it further

RESOLVED: That a copy of this resolution be sent to the Governor of the State of Michigan, to the Board of Trustees of the American Medical Association, to the members of the State Legislature, and to all members of Congress.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 7

Payments of Alternate Physicians in Obstetrics and Gynecology

Introduced by F. Michael Sheridan, M.D., Oakland

Whereas, the doctors of Oakland County endorse the principle of payments by Michigan Medical Service to the physician performing the service, and

Whereas, it is recognized that payments for services performed are not made to residents and interns, and

Whereas, the provision of obstetrical services is required at unpredictable times, and

Whereas, it is the responsibility of the obstetrician to make arrangements for the care of the patient in labor by an equivalent attending doctor if for any reason he cannot be in attendance, including absence from the city, illness, or patient in labor at one hospital while he is attending another patient in another hospital, and in cases where a locum tenens is employed, and

Whereas, the obstetrician is guilty of abandonment of his patient and subject to malpractice procedures if such arrangements are not made, and

Whereas, such arrangements between obstetricians and other physicians are neither unethical nor unusual, therefore be it

RESOLVED: That Michigan Medical Service make arrangements for payments to the doctor originally responsible for the care of the patient either by assignment of the payment by the doctor who performed the service to the original physician or by such other methods as will meet the requirements of these situations.

THE REFERENCE COMMITTEE on Medical Service and Prepayment Insurance, J. B. Blodgett, M.D., Chairman, considered Resolutions 7 and 28 together and recommended no action on either resolution for the following reason:

In obstetrical delivery the fee provided by the Michigan Medical Service is for the delivery itself and does not include payment for the prepartum or postpartum care.

Flexibility in service provisions to the patient is often desirable, and flexibility in payment arrangements can be provided by the individuals concerned.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 8

Changing the Name of the Michigan State Medical Society

Introduced by L. A. Drolett, M.D., Ingham

Whereas, a constitutional amendment is proposed to be acted upon at the 1965 MSMS Annual Session in Detroit to change the name of the Michigan State Medical Society to the Michigan Medical Association, and

Whereas, the reasons for such change have been explained as "other states are doing the same" and that the name Michigan State Medical Society connotates a state agency, and

Whereas, the new name would sound too much like a commercial association, and

Whereas, for 100 years the same name of the Society has existed as such, and we are a society of professional men and women banded together for professional good, therefore be it

RESOLVED: That we, the members of the Ingham County Medical Society, oppose such a constitutional amendment.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. Tupper, M.D., Chairman, recommended no action on this resolution since the House did not adopt the proposed Constitutional amendment regarding the name change.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 9

Legislation Re Practice of Medicine and Osteopathy

Introduced by Robert Stow, M.D., Ingham

Whereas, doctors of medicine have as their prime purpose the responsibility of the welfare of the people under their care, and

Whereas, organized medicine has as its goal the same purpose, and

Whereas, doctors of osteopathy have an identical goal, and

Whereas, the practice of osteopathy has progressed since its first school was established in Missouri, and

Whereas, practitioners of osteopathy perform with the same learning and skills as practitioners of medicine, and

Whereas, both doctors of osteopathy and doctors of medicine, mutually, wish to increase their learning and skills, therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society request The Council to have prepared a bill to present to the State Legislature at the earliest opportunity, declaring the practice of osteopathy and the practice of medicine, to be one and the same profession, and be it further

RESOLVED: That a Single Medical Practice Act be promulgated.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, recommended adoption of the following:

Substitute Resolution 9

"Whereas, doctors of medicine have as their prime purpose the responsibility of the welfare of the people of the State of Michigan, and

Whereas, doctors of osteopathy have an identical goal; therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society support The Council and its committees in their efforts to effect a workable program for the ultimate consolidation of medicine and osteopathy in the best interests of the health of the people of this state.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 10

Poll of AMA Members

Introduced by Henry Malcolm, M.D., Ingham

Whereas, the Ingham County Medical Society recognizes the increasing impact of social and political action upon physicians and the practice of medicine, and

Whereas, certain basic and far-reaching policy matters, pertaining especially to the approach of the American Medical Association to federal legislation, could advantageously first be approved by its entire membership, and

Whereas, we do not suggest pre-empting the legislative role from our nationally elected Delegates, we feel the entire membership could judge proposals in the light of their consciences, desires and knowledge of public opinion, and

Whereas, such approval would add weight to such a proposal and would allow our Delegates to feel certain they are realistically reflecting the attitudes of the members, and

Whereas, there is a value in the collected opinion of member physicians on proposals affecting the profession, and

Whereas, modern data processing equipment makes rapid polling of the physicians practicable, therefore be it

RESOLVED: That a method be developed by the American Medical Association whereby individual members of the AMA can vote by ballot on all decisions of importance concerning common interest and official policy.

THE REFERENCE COMMITTEE on Resolutions, H. M. Golden, M.D., Chairman, recommended disapproval since the proposal would be cumbersome, expensive, and would preempt the prerogatives of delegates.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 11

An Institute of Continuing Study of the Role of Medicine in Society

Introduced by D. Bonta Hiscoe, M.D., Ingham

Whereas, many changes are coming in our social structure over the next decades, particularly in the area of medical care and its distribution, and

Whereas, American medicine will be in need of a continuous supply of *objective* information concerning current social developments, current research in the social sciences as it pertains to medicine, and the most accurate possible predictions of future trends and developments in the structuring of medical care in a changing society, and

Whereas, with this type of information the American Medical Association in the future may be able to adopt more well-advised positions, and offer leadership in the social as well as in the scientific aspects of medical care, and

Whereas, it is very important that the American Medical Association make it known to the public by overt action that we wish to dispense the very best scientific medical care through the best social mechanism in the best interest of all concerned, and

Whereas, the California State Medical Society has demonstrated challenging leadership in presenting its study on "The Role of Medicine in Society," therefore be it

RESOLVED: That the California State Medical Society be congratulated for its pioneering efforts to study medicine in its total social setting, and that their efforts be amplified, and be it further

RESOLVED: That the American Medical Association establish an Institute for Continuing Study devoted to the exploration of medicine's role in society, and be it further

RESOLVED: That this Institute be an independent and objective institution, established at the same level as the Institute of Biomedical Research already functioning in Chicago, and be it further

RESOLVED: That information, statistics, libraries, and research obtained by the Institute be available to the American Medical Association for use in establishing its own policies, and be it further

RESOLVED: That on request the Institute act in an advisory capacity to the American Medical Association by drawing up alternative solutions to problems facing the profession, and be it further

RESOLVED: That a copy of this Resolution be forwarded to the American Medical Association for action.

THE REFERENCE COMMITTEE on Miscellaneous Business, V. V. Bass, M.D., Chairman, recommended approval of the resolution with the deletion of the first Resolved and amendment of the last Resolved so it would read:

RESOLVED: That this resolution be forwarded to the American Medical Association through the MSMS Delegation, and that they be instructed to introduce this resolution at the AMA House of Delegates.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 12

Drivers' Tetanus Immunization

Introduced by Paul Ivkovich, M.D., Mecosta-Osceola-Lake

Whereas, the 1964 House of Delegates to the Michigan State Medical Society recommended that medical information particularly re tetanus immunization be placed on Michigan drivers' licenses, and

Whereas, the stickers were obtained with MSMS identification that could be placed on the driver's license of the doctor's patient, therefore be it

RESOLVED: That each component medical society make this information cognizant to their members, and be it further

RESOLVED: That where feasible a component medical society engage in a crash program for mass immunization of drivers who have never been immunized to tetanus before under a program similar to one conducted for Sabin vaccine.

THE REFERENCE COMMITTEE on Hygiene and Public Health, B. E. Brush, M.D., Chairman, recommended approval of the resolution amending the second Resolved to read:

RESOLVED: That where needed a component medical society engage in a program for mass immunization against tetanus.

And adding a third Resolved to read:

RESOLVED: That drivers thus immunized be identified by a sticker attached to their driver's license.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 13

Stimulation of Legislation Allowing Cost of Medical Education to be Tax Deductible

Introduced by Fred C. Brace, M.D., Kent

Whereas, the population explosion in the United States is causing a critical situation in the demand for more and more physicians, and

Whereas, the length and scope of medical education increases the cost in excess of an average family's means, and

Whereas, a $787 million measure to spur an increase in medical manpower was approved by the National House of Representatives on September 1, 1965, which, in addition to construction and maintenance of medical schools, would allow a "needy" medical student to receive an outright grant of $2,500 annually, and

Whereas, equal opportunity should be available to all students to pursue the study of medicine in our "great society", therefore be it

RESOLVED: That our Delegates to the American Medical Association be instructed to stimulate legislation that would allow the cost of medical education to be tax deductible on an annual basis, and be it further

RESOLVED: That the Secretary of the Michigan State Medical Society be instructed to send a copy of this resolution to the members of the Senate and House of Representatives and the secretaries of all fifty component state medical societies urging their support.

THE REFERENCE COMMITTEE on Resolutions, H. M. Golden, M.D., Chairman, recommended disapproval of this resolution on the grounds of class legislation, that organized medicine has opposed federal subsidies in medicine, and that it would set a precedent for other groups to ask for special consideration and legislation.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 14

Endorsement of Poison Antidote Kit (PAK) Program

Introduced by Fred C. Brace, M.D., Kent

Whereas, the matter of accidental poisoning, particularly of young children, is a matter of grave concern of all health professionals, and

Whereas, the Michigan State Medical Society has previously endorsed and cooperated with the Michigan State Pharmaceutical Association in the snake-symbol warning label program designed to educate the public to the dangers of accidental poisoning, and

Whereas, the Michigan State Pharmaceutical Association has proposed an adjunctive poison prevention program and has requested the cooperation of the medical profession, therefore be it

RESOLVED: That the Michigan State Medical Society endorse the Poison Antidote Kit (PAK) program which involves distribution of an emergency kit containing one-half ounce of Syrup of Ipecac and fifteen grams of Activated Charcoal, labeled with appropriate warnings and directions for use, and be it further

RESOLVED: That the Michigan State Medical Society urge all physicians to cooperate in this interprofessional campaign to reduce the tragic toll of accidental poisoning, and be it further

RESOLVED: That the Secretary of the Michigan State Medical Society notify all members (either by brochure, news bulletin, or the Journal) of this action.

THE REFERENCE COMMITTEE on Hygiene and Public Health, B. E. Brush, M.D., Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 15

Utilization Committees

Introduced by W. Clarence Beets, M.D., Kent

Whereas, Public Law 89-97 calls for the establishment of Utilization Review Committees in participating hospitals and for the establishment of Utilization Review Committees to review care rendered outside the hospital, and

Whereas, the Utilization Review Committee must review:

(a) Admissions to institutions,
(b) Duration of stay,
(c) Professional services furnished, including drugs and biologicals,
(d) Medical necessity of these services, and
(e) The efficient use of available health facilities and services, and

Whereas, such committees could be composed in the majority by non-physician members, and

Whereas, a state-wide review committee could be established to audit individual Utilization Review Committees, and

Whereas, there could be established a national review committee under the law, and

Whereas, the aforementioned structure and activities of these committees could have an immediate and harmful effect on patient care, now therefore be it

RESOLVED: That such Utilization Review Committees must consist only of physicians and such physicians should be members of the respective hospital staff, and be it further

RESOLVED: That the responsibility of these committees must be to the members of the staff of the hospital only and that there can be no responsibility on the part of such committees to any outside agency, and be it further

RESOLVED: That whether such committees can properly conduct a study during the course of a patient's hospital stay can best be determined by each individual hospital staff, and be it further

RESOLVED: That recommendations of the Utilization Review Committees should be used as a mechanism in hospital staff discipline and not in the area of patient care, and be it further

RESOLVED: That the principles set forth in this resolution be communicated in the most effective manner to the task force and Board of Trustees of the American Medical Association and to the Department of Health, Education and Welfare to be included in the regulations of the bill, and be it further

RESOLVED: That this resolution be introduced through appropriate channels by the Delegates of the Michigan State Medical Society to the American Medical Association to the House of Delegates of the American Medical Association for action at its meeting in Chicago in October, 1965.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, recommended disapproval of this resolution, believing that Public Law 89-97 must be followed and utilization committees be established only as therein prescribed until such time as the Congress changes the law.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 16

Participation in Area-Wide Hospital Planning

Introduced by D. Bonta Hiscoe, M.D., Ingham

Whereas, the need for economy and efficiency in the dispensing of medical care has become obvious, and

Whereas, these goals can only really be accomplished by taking into consideration the needs of a whole area, and

Whereas, we wholeheartedly prefer the voluntary to the arbitrary approach, and

Whereas, physician participation is essential, therefore be it

RESOLVED: Michigan State Medical Society continue to support the Hospital Research and Educational Reserve of Michigan and the Michigan Health Facilities Planning Council in their efforts to establish a fair, reasonable and equitable voluntary approach to this problem, and be it further

RESOLVED: Local physicians be encouraged to take the initiative in establishing local and regional health planning councils.

THE REFERENCE COMMITTEE on Resolutions, H. M. Golden, M.D., Chairman, considered Resolutions 5 and 16 together and recommended adoption of the following:

Substitute Resolution

Whereas, the need for economy and efficiency in the dispensing of medical care has become obvious, and

Whereas, these goals can only be accomplished by taking into consideration the needs of the whole area; therefore be it

RESOLVED: That the Michigan State Medical Society recognize that area-wide hospital planning should be kept on a voluntary basis; and be it further

RESOLVED: That area-wide planning committees have adequate physician representation; and be it further

RESOLVED: That the Michigan State Medical Society continue to support the Hospital Research and Educational Reserve of Michigan and the Michigan Health Facilities Planning Council in their efforts to establish a fair, reasonable and equitable voluntary approach to this problem; and be it further

RESOLVED: That component medical societies take steps immediately to appoint committees that will take the initiative in forming local and regional health planning councils.

THE HOUSE adopted the recommendation of the Reference Committee.

RESOLUTION 17

Use of Maternity Beds for Non-Obstetric Patients

Introduced by Frederick C. Ryan, M.D., Kalamazoo

Whereas, there is an ever-increasing need for hospital beds, and

Whereas, there is often a low maternity bed occupancy in many hospitals throughout the state, and

Whereas, the Joint Commission on Accreditation of Hospitals in its Bulletin No. 38 states that the Commission is now planning "to allow, if necessary, under specific controls, the presence of clean gynecological and surgical cases in the obstetrical unit," therefore be it

RESOLVED: That the Maternal and Child Health Division of the Michigan Department of Health alter its regulations to conform to this policy.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, recommended no action on this resolution, believing that some obstetrical units cannot be modified without excessive expense to comply with acceptable "swing units" as approved by the Michigan Department of Health and such unacceptable units would not be in the best interests of patients.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 18

Temporary Seating of an Alternate Delegate

Introduced by Wyman C. C. Cole, Jr., M.D., Wayne

Whereas, Chapter 9, Sec. 4 of the Michigan State Medical Society Bylaws states:

> "Once seated, a Delegate shall remain a Delegate throughout the entire Session and thereafter until the next Annual Session of the House of Delegates and his place shall not be taken by any other Delegate or Alternate Delegate except that in case of emergency the House of Delegates may seat a duly accredited Alternate Delegate from the same component county society" and

Whereas, each Delegate of the Michigan State Medical Society has an elected Alternate, and

Whereas, the Bylaws of the American Medical Association provide that "if the delegate is not present, his place may be taken during the period of his absence by an alternate or a substitute alternate," therefore be it

RESOLVED: That the Committee on Constitution and Bylaws be requested to prepare an amendment to Chapter 9, Sec. 4 of the Michigan State Medical Society Bylaws to provide for temporary seating of an alternate, similar to the Bylaws of the American Medical Association.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. Tupper, M.D., Chairman, recommended approval of the resolution and in accordance with the Resolved submitted the following amendments to the Bylaws, Chapter 9, Sec. 4, so it would read:

Sec. 4 Seating—Tenure—A delegate, or in his absence, an alternate delegate (in order of seniority) becomes a member of the House of Delegates when duly registered and seated at the Annual Session following his election and certification by the component county society. If a Delegate is not present, his place may be taken during the period of his absence by an Alternate Delegate from the same component county society.

THE HOUSE adopted the Committee's recommendation to approve Resolution 18 and at the next meeting of the House, adopted the proposed Bylaws amendments.

RESOLUTION 19

Definition of Governmental Obligations in Public Health

Introduced by L. E. Holly, II, M.D., Muskegon

Whereas, the 1964-1965 Report of the MSMS Committee on Public Health concerning the substitute for resolutions Nos. 10 and 17 of the 1964 House of Delegates session was disapproved by The MSMS Council on July 22, 1965, and

Whereas, the need for a clear delineation of the role of government in caring for the health of people is ever increasing in priority, therefore be it

RESOLVED: That the Michigan State Medical Society make a clear distinction between public health where government using public money and resources has proper and primary concern and public health where government using public money and resources operates only in an assistive or cooperative capacity with non-governmental groups.

THE REFERENCE COMMITTEE on Hygiene and Public Health, B. E. Brush, M.D., Chairman, recommended that this resolution be not approved.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 20

A Development in Medical Education

Introduced by William G. Birch, M.D., Kalamazoo

Whereas, the medical profession is being increasingly concerned with the expansion of health services to a rapidly expanding population without completely effective means of educating sufficient medical doctors to supply this need as currently defined, and

Whereas, ancillary personnel are already being trained and used in certain areas such as anesthesia, pathology, orthopedics, obstetrics, research and nursing—such as nurse anesthetists, bacteriologists, physiotherapists, midwives, zoologists, and licensed practical nurses, and

Whereas, the medical profession is called upon to perform modern miracles which are increasingly time-consuming in training, diagnostics and management, and

Whereas, the effective and successful practice of modern medicine is becoming stressful to the limits of human endurance—shortening the lives and depleting the endurance of said members of the medical profession, be it therefor

RESOLVED: That the Michigan State Medical Society go on record as favoring, and request the American Medical Association to investigate, develop, and implement a program of training at the college level, for those who qualify, as medical assistants granting them a baccalaureate degree in medical science under medical school supervision, and be it further

RESOLVED: That the American Medical Association be empowered to encourage the various states to license and regulate under their medical practice acts such individuals to perform under supervision of doctors of medicine such routine procedures as their training qualifies them for, thereby extending the efficiency and effectiveness of the medical profession.

THE REFERENCE COMMITTEE on Miscellaneous Business, V. V. Bass, M.D., Chairman, recommended adoption of the following substitute resolution:

Substitute Resolution No. 20

Whereas, the medical profession is being increasingly concerned with the expansion of health services to meet the needs of a rapidly expanding population, and

Whereas, the demographers predict that in 1980 there will be 76 million children under 15 years of age, and

Whereas, currently there are 18 million persons over 65 and it is estimated there will be 30 to 40 million persons over 65 by 1980, and

Whereas, the physician population in actual private practice per 100,000 population has been steadily decreasing, although the total number of physicians per 100,000 population has remained static, and

Whereas, the medical profession is called upon to perform

modern miracles which are increasingly time-consuming in training, diagnostics and management, and

Whereas, ancillary personnel are already being trained and functioning in certain areas such as anesthesia, pathology, orthopedics, obstetrics, research, nursing, bacteriologists, physiotherapists, midwives, nurse anesthetists, and licensed practical nurses; therefore, be it

RESOLVED: That The Council of the Michigan State Medical Society appoint a joint committee, consisting of members from medical societies, medical schools, and the State Board of Education, to consider areas of training, qualifications, and degrees of limitations, and control of medical ancillary personnel, and to investigate and consider the feasibility of developing and implementing a program of training at the college level as medical assistants under medical school supervision; and be it further

RESOLVED: That the American Medical Association be apprised of this action and that it be respectfully suggested to the AMA that they take steps considered appropriate on a national level to develop similar programs of the non-physician provisions of health care.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 21

Reapportionment of MSMS House of Delegates

Introduced by John W. Moses, M.D., Wayne

Whereas, the principle of "one man-one vote" is fundamental to the democratic process; and

Whereas, the areas in Michigan with the greater densities of physician population are not at present proportionately represented in the House of Delegates of the Michigan State Medical Society, nor The Council of the Michigan State Medical Society, nor in the Delegation from Michigan to the House of Delegates of the American Medical Association; therefore be it

RESOLVED: That the Speaker of this House of Delegates appoint an ad hoc committee of which the membership is to be on the basis of density of physician population in this state, to study the geographical distribution of physicians in Michigan to obtain proper reapportionment on a "one man-one vote" basis of the House of Delegates and The Council of the Michigan State Medical Society, the Delegation from Michigan to the American Medical Association House of Delegates; and be it further

RESOLVED: That this committee report its findings and recommendations, together with suitable Constitution and Bylaw changes to implement them, to the 1966 meeting of this House of Delegates.

THE REFERENCE COMMITTEE on Resolutions, H. M. Golden, M.D., Chairman, recommended approval of the resolution with the two Resolved portions amended as follows:

RESOLVED: That the Speaker of this House of Delegates appoint an ad hoc committee, of which the membership is to be on the basis of density of physician population in this State, to study the geographical distribution of physicians in Michigan and study the feasibility of reapportionment on a one-man, one-vote basis of the House of Delegates and The Council of the Michigan State Medical Society and the delegation from Michigan to the American Medical Association House of Delegates; and be it further

RESOLVED: That this committee report its findings and recommendations to the 1966 meeting of this House of Delegates.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 22

Study of the Organization of the Medical Profession

Introduced by Frank H. Power, M.D., Grand Traverse-Leelanau-Benzie

Whereas, the objective of the medical profession has always been, and will continue to be, the provision of the best possible professional medical care for the people of this nation, and

Whereas, the profession views with grave concern recent socio-political developments which will assuredly, and ultimately, depreciate the quality of this professional medical care, and which adverse developments the profession was powerless to prevent, or even to significantly modify, and

Whereas, it is to be noted that certain other well-organized craft and professional groups, by virtue of their type of organization and administration, have been amazingly effective in accomplishing their stated goals, and

Whereas, it is anticipated that the medical profession will be repeatedly reminded of its ineffectiveness in this regard, in the near future, which ineffectiveness will largely arise from lack of assurance of solid, unified support of its objectives and methods, by all members of the profession, now therefore be it

RESOLVED: That this House of Delegates of the Michigan State Medical Society hereby directs its Delegates to the House of Delegates of the American Medical Association to introduce and support a suitable resolution asking that a special study committee be appointed, or other appropriate steps taken, to explore and to evaluate the feasibility of reorientation and reorganization of the American Medical Association, together with state and local medical societies, looking toward the provision of a more effective and authoritarian organization structure to implement the objectives and goals of the medical profession of the United States, and be it further

RESOLVED: That copies of this resolution be sent to the appropriate officers of the other State Medical Societies for their information and guidance, and to be passed on to their delegates to the American Medical Association.

THE REFERENCE COMMITTEE on Miscellaneous Business, V. V. Bass, M.D., Chairman, recommended approval of the resolution with minor amendments in the Resolved portion, so that it would read as follows:

RESOLVED: That this House of Delegates of the Michigan State Medical Society hereby directs its Delegates to the House of Delegates of the American Medical Association to introduce and support a suitable resolution asking that a special study committee be appointed, or other appropriate steps taken, to explore and to evaluate the feasibility of reorientation and reorganization of the American Medical Association, together with state and local medical societies, looking toward the provision of a more effective organization structure to implement the objectives and goals of the medical profession of the United States.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 23

Physicians Under Public Law 89-97

Introduced by Robert Prophater, M.D., Bay-Arenac-Iosco

Whereas, Public Law 89-97 is now the law of the United States and will have a profound impact on the practice of medicine and the health care of the citizens of Michigan, therefore be it

RESOLVED: That the Michigan State Medical Society shall give top priority in its activities by: (1) Meeting with governmental agencies and all interested parties to assure the best possible medical care for our patients by conferring on the implementation and regulations under the law; (2) fully informing the medical profession and the public on the development of details and regulations under the law; (3) urging that in the implementation of the provisions of all public assistance acts that physicians and other providers of health service be compensated on a usual and customary basis, and be it further

RESOLVED: That each physician must act on his own decision under Public Law 89-97 as no organization has the authority to dictate to the individual physician.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, recommended deletion of the first Resolved and approval of the resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 24

Approval of 1965 Relative Value Study

Introduced by Paul J. Connolly, M.D., Wayne

Whereas, committees of the Michigan State Medical Society have studied the development of a Relative Value Schedule for use in Michigan for more than four years, and

Whereas, the most recent changes appear to improve on inequities present in the schedule now being used by Michigan Medical Service, and

Whereas, the 1965 proposal should be subject to continued adjustment, therefore be it

RESOLVED: That the 1965 Relative Value Study be approved, and be it further

RESOLVED: That the Relative Value Study Committee be a continuing committee to re-evaluate the schedule at quarterly intervals.

THE REFERENCE COMMITTEE on Reports of Special Committees, D. N. Sweeny, Jr., M.D., Chairman, recommended no action since the intent of the resolution had been accomplished by the action of the House on the Annual Report of the Relative Value Study Committee.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 25

Uniformity of Fee Schedules

Introduced by G. Thomas McKean, M.D., Wayne

Whereas, there are multiple schedules of payments now being used by different branches of government for services of physicians, and

Whereas, it is becoming increasingly important that there be uniformity in payments from any branch of government, therefore be it

RESOLVED: That The Council of the Michigan State Medical Society promptly take action to review the existing schedules to produce such uniformity in payments by all branches of government.

THE REFERENCE COMMITTEE on Miscellaneous Business, V. V. Bass, M.D., Chairman, "felt the numerous and varied fee schedules of the many governmental agencies needed reviewing, but felt The Council should have some latitude in the establishment of uniformity."

Therefore, the Reference Committee recommended approval of this resolution after amending the Resolved to read:

RESOLVED: That The Council of the Michigan State Medical Society promptly take action to review the existing schedules and to consider feasibility of establishing uniformity in payments of all branches of government.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 26

Establishment of an MSMS Section of Plastic Surgery

Introduced by Robert Swanson, M.D., Wayne

Whereas, the number of plastic surgeons in Michigan is steadily increasing, and

Whereas, plastic surgery is achieving increasing importance in the practice of medicine, and

Whereas, these plastic surgeons desire to participate in the educational efforts of the Michigan State Medical Society and to contribute to the program of the Scientific Session of the Michigan State Medical Society, therefore be it

RESOLVED: That a Section of Plastic Surgery be established in the Michigan State Medical Society.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. Tupper, M.D., Chairman, recommended no action since the intent of the resolution had been accomplished when the House adopted the Annual Report of the Constitution and Bylaws Committee.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 27

Fiscal Agent for Medicare

Introduced by Edgar E. Martmer, M.D., Wayne

Whereas, Public Law 89-97 of 1965, Section 1842, authorizes the Secretary of Health, Education and Welfare to enter into contracts with carriers to perform the following functions:

"(1) (a) Make determinations of the rates and amounts of payments . . . to be made to providers of services and other persons on a reasonable cost or reasonable charge basis . . .;
    (b) Receive, disburse, and account for funds in making such payments;
    (c) Make such audits of the records of providers of services as may be necessary to assure proper payments . . .;
(2) (a) Determine compliance with the requirements of Section 1861 (k) as to utilization review;
    (b) Assist providers of services and other persons in the development of procedures relating to utilization practices, make studies of the effectiveness of the procedures and methods for their improvement, assist in application of safeguards against unnecessary utilization of services . . ., and provide procedures for and assist in arranging, where necessary, for the establishment of groups outside hospitals to . . . make utilization reviews;
(3) Serve as a channel of communication of information relating to the administration of this part; and
(4) Assist in such manner as the contract may provide in discharging administrative duties . . .;" and

Whereas, Michigan Medical Service has performed similar functions satisfactorily for many years, to the benefit of its subscribers and the doctors of Michigan; and

Whereas, the staff of Michigan Medical Service is skilled and experienced in implementing such programs, and has well-established lines of communications with physicians and subscribers; therefore be it

RESOLVED: That the House of Delegates recommend to the Secretary of Health, Education and Welfare that Michigan Medical Service be designated in the State of Michigan as fiscal agent under provisions of Public Law 89-97, titled "Use of Public Agencies or Private Organizations to Facilitate Payment to Providers of Services," Section 1816.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, recommended that the resolution be amended by substituting the word "administrative" for the word "fiscal" in the title of the Resolution and in the third line of the Resolved portion.

THE HOUSE did not adopt the recommendation of the Reference Committee, but adopted Resolution 27 without amendment.

RESOLUTION 28

Doctor's Service Reports, Michigan Medical Service

Introduced by Vernon V. Bass, M.D., Saginaw

Whereas, it is current policy of Michigan Medical Service to require the individual physician rendering a specific subscriber service to personally sign the Doctor's Service Report for such services, and

Whereas, in the modern practice of medicine, with formal and informal group arrangements in order to effect proper full-time availability for patient care, there are frequently several physicians involved, and

Whereas, this greatly complicates the proper rendering of Doctor's Service Reports and creates considerable confusion as well as increases the operating expenses of many physicians' offices and, in addition, leads to patient, physician, and Michigan Medical Service misunderstandings, and

Whereas, physicians, in general, are honest and ethical, and, therefore, in general, should not be penalized because of the possible exploitation by a few physicians, therefore be it

RESOLVED: That the House of Delegates, Michigan State Medical Society, acting in its capacity as the Corporate Body of Michigan Medical Service, advise the Board of Directors of Michigan Medical Service to immediately take steps to remedy this present complicated billing procedure and permit one physician, in agreement with his colleagues involved in rendering a particular subscriber service, to sign the Doctor's Service Report for himself and his associates, as long as neither he nor his associates rendering the service are interns, residents, or physicians in training.

THE REFERENCE COMMITTEE on Medical Service and Prepayment Insurance, J. B. Blodgett, M.D., Chairman, considered Resolutions 7 and 28 together.

For Reference Committee and House action see Resolution 7.

RESOLUTION 29

Change of Meeting Date of Michigan State Medical Society

Introduced by Hugh T. Caumartin, M.D., Saginaw

Whereas, most county medical societies do not hold regular meetings during the summer months, and

Whereas, the September meeting of county societies is chronologically juxtaposed to the annual Michigan State Medical Society House of Delegates session, and

Whereas, this does not give component county society membership adequate opportunity to properly consider legislative problems prior to the annual Michigan State Medical Society meeting, and

Whereas, the annual session of the Michigan State Medical Society House of Delegates considerably antedates the sessions of the American Medical Association, therefore be it

RESOLVED: That the House of Delegates, Michigan State Medical Society, seriously consider changing the date of its annual meeting to a more appropriate time of the year (e.g., November or March), and be it further

RESOLVED: That this matter be referred to an appropriate committee of The Council for study and for subsequent recommendation at the next annual session of the House of Delegates.

THIS REFERENCE COMMITTEE on Constitution and Bylaws, H. M. Golden, M.D., Chairman, recommended deletion of the words "e.g., November or March)" in the first Resolved and approval of the Resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 30

Disapproval of Monetary Value for RVS

Introduced by Donald N. Sweeny, Jr., M.D., Wayne

Whereas, dollar values set for units in the Relative Value Schedule must be adjusted regularly, and

Whereas, there exist unresolved questions as to the legality of a state medical society setting dollar values, therefore be it

RESOLVED: That no monetary value be established for the Relative Value Study at this time.

THE REFERENCE COMMITTEE on Reports of Special Committees, D. N. Sweeny, Jr., M.D., Chairman, presented the following report:

"This resolution concerns itself with the assigning of a monetary value to the Relative Value Study 1965. Your Reference Committee reviewed this problem thoroughly and was of the opinion that a fixed monetary value applied to the Relative Value Study at this time would not allow for the anticipated need for flexibility in the future.

"We carefully considered whose responsibility it should be to determine this conversion factor when the need should arise so that the resulting fees will be 'usual and customary.' Therefore, because of the possible urgency of the situation and the necessity for a small, effective and representative unit, we recommend that a committee of the House of Delegates, appointed by the Speaker, composed of nine members of the Michigan State Medical Society, who are preferably either officers, Councilors or Delegates, be vested with this power.

"We further recommend adoption of Resolution 30 with the deletion of the second whereas."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 31

Preparation of a Relative Value Study for the Professional Component of Pathology Services

Introduced by W. L. Brosius, M.D., Wayne

Whereas, recently enacted Public Law 89-97 (Medicare) makes provision for the payment of professional pathology fees to the pathologist separately from the payment of costs of operation of the laboratory, therefore be it

RESOLVED: That this House of Delegates direct the preparation of a Relative Value Study for the professional component of pathology services by an appropriate committee or committees.

THE REFERENCE COMMITTEE on Reports of Special Committees, D. N. Sweeny, Jr., M.D., Chairman, recommended adoption of the resolution with the Resolving portion amended as follows:

RESOLVED: That this House of Delegates direct the preparation of a Relative Value Study for the professional component of pathology services by an appropriate committee or committees in consultation with the Michigan Society of Pathologists.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 32

Modernization of Medical Practice Laws

Introduced by W. L. Brosius, M.D., Wayne

Whereas, the Medical Practice Laws of the State of Michigan currently in force were originally adopted in 1899 and have been amended only in a minor way on several occasions, and

Whereas, two new constitutions have been adopted by the State of Michigan since the Medical Practice laws were put into force, and

Whereas, during the intervening years there have been innumerable and unparalleled advances in scientific knowledge, as well as legal changes affecting the practice of medicine, and

Whereas, many medical specialties such as allergy, anesthesiology, pathology, radiology and others were unknown at the time of adoption of these laws, and

Whereas, many currently approved methods of diagnosis and treatment of human disease were formerly unknown, or not considered or defined as the practice of medicine, and

Whereas, the medical practice laws must reflect currently approved methods of diagnosis and treatment of human illness in order that the health of the people of Michigan can be properly protected and improved, and

Whereas, the recent enactment of Medicare legislation makes a clear definition of the practice of medicine extremely important, now therefore be it

RESOLVED: That this House of Delegates and the entire membership of the Michigan State Medical Society use their total influence to secure modernization of the Medical Practice Laws of this State at the earliest possible moment, and be it further

RESOLVED: That such action be initiated immediately through activities of The Council of this Society and any appropriate committees that The Council deems necessary, and be it further

RESOLVED: That The Council with the help of other appropriate committees of the Society be requested to prepare a bill for presentation to the State Legislature at the earliest opportunity embodying the necessary changes in the Medical Practice Laws to carry out the intent of this resolution.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, recommended the adoption of the resolution and the referral of it to The Council for implementation at the time which, in its judgment, is most suitable to attain the greatest good.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 33

Opposition to the Douglas Amendment

Introduced by W. Clarence Beets, M.D., Kent

Whereas, the diagnosis and treatment of patients by the methods of radiology, anesthesia, pathology and physiatry are incontrovertibly a portion of the practice of medicine, and

Whereas, the practice of medicine can legally be performed only by individuals licensed to practice the healing arts, and

Whereas, no corporate entity, association or institution of any sort can be licensed to practice medicine, and

Whereas, the proposed Douglas Amendment to the Medicare Bill would provide for treatment of radiologic, anesthetic, pathologic, and physiatric services as hospital services rather than as professional services, therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society hereby reaffirm its determined opposition to the Douglas Amendment, and be it further

RESOLVED: That a copy of this resolution be transmitted to each of the United States Senators and Representatives from Michigan and to the American Medical Association.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, recommended the resolution be approved.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 34

Crippled Children Commission

Introduced by A. Jackson Day, M.D., Wayne

Whereas, the Michigan State Board of Health is concerned with the prevention and control of disease, and

Whereas, the Michigan Crippled Children Commission is concerned with the treatment of diseases and related abnormalities, therefore be it

RESOLVED: That the Michigan State Medical Society support the continued autonomy of the Michigan Crippled Children Commission as a treatment commission not governed by the State Board of Health, and be it further

RESOLVED: That this decision be transmitted to the Governor of Michigan and to appropriate committees of the Michigan State Legislature.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, recommended no action on this resolution "inasmuch as the Legislature and the Governor have already acted to establish the MCCC under the Michigan Department of Health as a 'Class 11 Transfer,' which enables it to retain its own Board and making it responsible to the Director of the Department of Health and the Governor . . ."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 35

Appointment of Committee on Medicare

Introduced by Orlen J. Johnson, M.D., Delegate-at-Large

Whereas, there are increasing demands that the medical profession closely follow the implementation of Medicare, and

Whereas, there is no committee with the sole responsibility of working on this matter, therefore be it

RESOLVED: That the president of the Michigan State Medical Society appoint a committee to work with governmental agencies and private organizations in this field, and be it further

RESOLVED: This committee shall also keep the public and the medical profession informed.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, considered Resolutions 1, 35 and 45 together and recommended the adoption of the following:

Substitute for Resolutions 1, 35, 45.

Whereas, there are increasing demands that the medical profession closely follow implementation of Medicare, and

Whereas, there is no committee of the Michigan State Medical Society solely concerned with the responsibility of working on this matter, and

Whereas, there is a need for negotiating a single, truly uniform method of payment based upon the usual and customary fees applicable to all governmentally-sponsored medical care programs, and

Whereas, there is a need for periodic dissemination of information to the profession and to the public; therefore, be it

RESOLVED: That the President of the Michigan State Medical Society appoint a committee, to be called the Committee on Governmental Medical Care Programs, for the following purposes:

1—To represent the Michigan State Medical Society in all matters concerning the so-called Medicare program, Public Law 89-97;

2—To provide a body with whom the administrative agent shall discuss all matters involving the purveyors of medical services prior to any present or future negotiations which said administrative agent may have with any governmental agency;

3—To be concerned with the activities and planning of other governmental agencies involved in the medical care field, with particular reference to the negotiations of fees paid to physicians;

4—To keep the public and the medical profession informed on developments concerning the implementation of the Medicare program;

5—To make reports and recommendations to the President and to The Council of the Michigan State Medical Society; and be it further

RESOLVED: That this Committee shall consist of nine members who shall be appointed for a period of three years, the appointments being staggered initially so that three are appointed for three years, three for two years, and three for one year, and provided that no member of this Committee may serve concurrently on the Board of Directors of Michigan Medical Service.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 36

President's Commission Report on Heart Diseases, Strokes and Cancer—Implementation and Cooperation by MSMS

Introduced by John R. Pedden, M.D., Kent

Whereas, the Congress of the United States is currently considering legislation to implement the President's Commission program to conquer heart disease, cancer, and strokes, and

Whereas, the use of federal funds to fight these dread diseases can be most effectively used in the expansion of existing facilities, and

Whereas, the equitable distribution of increasingly scarce physicians is threatened by the creation of new regional centers to the detriment of patient care, and

Whereas, the medical profession has always fought for the best medical care of all diseases for the people of this country, therefore be it

RESOLVED: That Michigan State Medical Society urge the Congress of the United States to implement the desirable objectives of the President's Commission Report on Strokes, Heart Disease and Cancer and to conserve medical manpower by expansion and utilization of all existing resources and facilities in consultation and cooperation with the American Medical Association and constituent State Medical Societies.

THE REFERENCE COMMITTEE on Miscellaneous Business, V. V. Bass, M.D., Chairman, recommended approval of the resolution with the deletion of the word "all" in the Resolved portion.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 37

Laboratory Medicine

Introduced by D. L. Hinerman, M.D., Washtenaw

Whereas, a medical laboratory is any facility which through its operation employs methods to examine tissues, fluids, secretions, and excretions of the human body for the purpose of detecting or diagnosing disease, to follow its course, or to aid in its treatment, and

Whereas, the efficiency and accuracy of a medical laboratory are dependent upon adequate supervisions and the skill and training of its personnel, therefore be it

RESOLVED: That the operation of a medical laboratory as defined represents the practice of medicine, and be it further

RESOLVED: That the Michigan State Medical Society adopt the principle that a medical laboratory should be actively supervised and directed by a licensed physician, and be it further

RESOLVED: That any person shall be regarded as practicing medicine who shall diagnose, or profess to diagnose, or perform laboratory examinations to aid in the diagnosis and treatment of human disease, and be it further

RESOLVED: That the House of Delegates and the entire membership of the Michigan State Medical Society take such steps as is necessary to implement this Resolution which is in accord with similar actions taken previously by the American Medical Association.

THE REFERENCE COMMITTEE on Resolutions, H. M. Golden, M.D., Chairman, recommended deletion of the word "actively" from line 3 in the second Resolved, deletion of the entire third Resolved, and amendment of the fourth Resolved to read as follows:

RESOLVED: That the House of Delegates through The Council refer this resolution to the Legal Affairs Committee for implementation and presentation to the Michigan State Legislature.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 38

Official Use of Title "Doctor"

Introduced by Robert F. Powers, M.D., Saginaw

Whereas, there is a constantly increasing number of persons who arbitrarily call themselves "doctor," and

Whereas, to allow unqualified persons to entitle themselves doctor perpetrates a misconception among the public, and

Whereas, the title of doctor not only implies a practitioner of the healing arts, but also implies undergraduate training at the college level leading to a degree followed by at least four years of postgraduate training at a qualified university, and

Whereas, it is the responsibility of our profession to constantly improve the standards of the practice of medicine, therefore be it

RESOLVED: That the Michigan State Medical Society, through its legislative committee, study the feasibility of sponsoring and actively supporting legislation to restrict the use of the title "doctor" to those persons who have by adequate postgraduate study at the university level and who have in the true and time-honored tradition of academic excellence attained the degree of doctor in their chosen field, and therefore be it further

RESOLVED: That the Michigan State Medical Society also sponsor legislation which would require identifying initials be used when a doctor is referred to in any publication.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, recommended no action although it "was in sympathy with the intent of this resolution." It felt that the use of identifying initials in reference to "doctor" in any publication is a matter of pride and should not be legislated.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 39

Preparation of a Relative Value Fee Scale to Cover Professional Services Only for Diagnostic Radiology

Introduced by Edwin O. Pearson, M.D., Kalamazoo

Whereas, the recent Medicare legislation, Public Law 89-97, contemplates provision for payment of professional radiologic fees to the radiologist in hospital practice separately from the payment of costs to the hospital, and

Whereas, the Relative Value Scale as currently presented by the Relative Value Study Committee provides such a Professional Services Only Scale for Radiation Therapy and for Radio-isotope use but (for lack of time) did not provide such a scale for Diagnostic Radiology, therefore be it

RESOLVED: That a Relative Value Study Committee be directed to produce a Relative Value Scale for Professional Services Only for Diagnostic Radiology.

THE REFERENCE COMMITTEE on Reports of Special Committees, D. N. Sweeny, Jr., M.D., Chairman, recommended adoption of this resolution with the deletion of the phrase ("for lack of time") from the second Whereas.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 40

Home Care

Introduced by Harold F. Falls, M.D., Washtenaw

Whereas, home care is the oldest form of medical care we know, and

Whereas, it is a well-known fact that home care has been the role of practicing physicians for a long time, and

Whereas, coordinated home care, as developed in Michigan, is growing in both Detroit and numerous other cities of various sizes in the state, and

Whereas, the continued growth of coordinated home care in Michigan is desirable because,

1. It reduces the total cost of illness;
2. It shortens hospitalization and prevents re-hospitalization;
3. It improves the utilization of existing hospital facilities;
4. It lessens and postpones the need for new hospital beds;
5. It preserves the patient's resources, thus preventing much medical indigency;
6. It expedites recovery from illness and prevents much disability; and

Whereas, there is evidence in other programs in the United States that physician participation and support in coordinated home care is stimulated by compensating the physician for his services to the home care patient, and

Whereas, formulas for physician payment for home care have been shown to be economically and actuarially sound, therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society urge Blue Shield (Michigan Medical Service) to support and participate in coordinated home care programs by providing suitable payment to the physician responsible for the patient's care at home.

THE REFERENCE COMMITTEE on Medical Service and Prepayment Insurance, J. B. Blodgett, M.D., Chairman, recommended adoption of the resolution, amending the Resolved to read as follows:

RESOLVED: That the House of Delegates urges Michigan Medical Service to continue its study of Home Care Programs for the purpose of providing physicians' service benefits to subscribers in coordinated Home Care Programs.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 41

Statute for "Implied Consent" Provision in Granting Motor Vehicle Drivers' Licenses

Introduced by Harvey M. Andre, M.D., Kent

Whereas, statistics reveal that 50%, or more, of all fatal motor vehicle accidents involve drinking drivers, and

Whereas, the highways are constantly becoming more congested with motor vehicles, and statistics reveal that the consumption of alcohol is increasing, and

Whereas, the medical profession is concerned not only with the restoration of diseased and injured persons to health, but also with the prevention of injury, disease and death, therefore be it

RESOLVED: That the MSMS encourage the enactment of statutes by the State Legislature providing for the mandatory determination of blood alcohol, or the use of approved breathing tests, on drivers suspected of having sufficient alcohol to impair their driving, and that any M.D. or D.O. who performs such a test at the request of a police officer, sheriff or deputy sheriff, shall be protected in the event of any court action which might later arise, by the conclusive presumption that it was done with the consent of the driver.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, recommended that this resolution be referred to The Council for implementation at the most opportune time, for the Committee believed there was a legislative bill being prepared which encompassed the intent of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 42

Continuation Education Programs

Introduced by John M. Sheldon, M.D., Washtenaw

Whereas, the doctors of the State of Michigan have taken leadership in the past in continuing medical education, and

Whereas, the Michigan State Medical Society and its component units, the Michigan Department of Health, and the two medical schools of the state have taken an active and pioneer interest in providing programs of continuing education, therefore be it

RESOLVED: That, in this, our Centennial Year, every member of the State Society be urged to attend and participate in one or more of the continuation education programs which are offered each year.

THE REFERENCE COMMITTEE on Resolutions, H. M. Golden, M.D., Chairman, recommended approval of the resolution as presented.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 43

Hospitalization of Clean Gynecological Patients in Obstetrical Departments

Introduced by Hugh T. Caumartin, M.D., Saginaw

Whereas, as indicated in Bulletin No. 38, the Joint Commission on Accreditation of Hospitals has recently altered its rules on hospitalization of other than obstetrical cases in the obstetrical departments of hospitals, the Commission now planning "to allow, if necessary, under specific controls, the presence of clean gynecological and surgical cases on the obstetrical unit," and

Whereas, obstetrical departments characteristically operate at a financial loss and currently, in spite of the shortage of available beds on other hospital clinical services, many hospitals have an average obstetrical occupancy rate of only 40 to 50%, and

Whereas, this adds greatly to the totality of hospital expenses as well as limits needed bed facilities, therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society request the Michigan Department of Health to seriously consider adjusting its rules to correspond basically with those of the Joint Commission on Accreditation of Hospitals.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, recommended no action on this resolution, believing that some obstetrical units cannot be modified without excessive expense to comply with acceptable "swing units" as approved by the Michigan Department of Health and such unacceptable units would not be in the best interests of patients.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 44

Remuneration of Utilization Committees in Hospitals Participating in Medicare

Introduced by Hugh T. Caumartin, M.D., Saginaw

Whereas, among the other governmental demands for approval of a hospital as a participating member in the care of patients eligible for Medicare under the Social Security Program, a hospital utilization committee is mandatory, and

Whereas, service on such a committee necessitates considerable time involvement on the part of the committee members, as well as the development of strained relations between such members and their local colleagues, and

Whereas, service on such committees has been offered as a support for the voluntary practice of medicine, and

Whereas, with the passage of Medicare, service rendered for beneficiaries of this program no longer involves the preservation of the private voluntary practice of medicine, therefore be it

RESOLVED: That since it would be anticipated that physicians serving on such committees for the benefit of the Federal Government Program would, in ordinary democratic fashion, be remunerated for such services at a "reasonable" level, that these physicians be so remunerated that such monies, rather than being accepted by the physician committee members, be relegated to a hospital staff or educational fund which could be utilized to enhance the care of patients.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, recommended disapproval of this resolution, feeling that if such remuneration as that mentioned in the Resolved portion is ever forthcoming, its distribution is the prerogative of the individual doctor or the hospital staff on which utilization committee he serves, rather than a determination of this House of Delegates.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 45

MSMS Negotiations with Medicare.

Introduced by Francis P. McQuillan, M.D., Jackson

Whereas, Michigan Medical Service will probably be the governmental fiscal agent selected to administer Medicare under Public Law 89-97, and

Whereas, Michigan Medical Service would then be the administrative representative of a governmental agency for negotiating a fee schedule with the Michigan State Medical Society, therefore be it

RESOLVED: That any committee appointed as the representative of the Michigan State Medical Society for negotiations with the Michigan Medical Service shall have no member who is also a member of the Board of Directors of Michigan Medical Service.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., chairman, considered Resolutions 1, 35 and 45 together.

For Reference Committee and House action, see Resolution 35.

RESOLUTION 46

Automobile Safety Design Research Committee

Introduced by Frederick S. Gillett, M.D., Kent

Whereas the morbidity and mortality from automobile accidents has reached epidemic proportions, and

Whereas, preventive medicine is one of the responsibilities of a doctor of medicine, and

Whereas, medical physicians have done the majority of auto safety research, and

Whereas, aerospace medical data should be applied to auto safety, therefore be it

RESOLVED: That The Council of the Michigan State Medical Society appoint an Auto Safety Design Commission made up of appropriate medical personnel, and be it further

RESOLVED: That this Commission be directed to solicit the management of the automotive industry in Michigan to furnish appropriate engineering talent to further research advanced safety features in car design.

THE REFERENCE COMMITTEE on Miscellaneous Business, V. V. Bass, M.D., Chairman, recommended approval of this resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 47

Intern and Resident Relation & Training

Introduced by Louis E. Heideman, M.D., Wayne

Whereas, the role of the intern and the resident in our hospitals is in a state of flux, and

Whereas, responsibility for training is being reviewed by various groups, and

Whereas, the presence of interns and residents in hospitals has saved lives and suffering through prompt medical direction of acute situations, and

Whereas, there are and will continue to be for an unknown period many unfilled internships and residencies, therefore be it

RESOLVED: That an ad hoc committee be appointed to study and make recommendations for the State of Michigan regarding:

1. Purpose of internship and residencies
2. Responsibility for training
3. Responsibilities delegated to
   a. interns
   b. residents
4. Legal status of interns and residents
5. Remuneration of interns and residents
6. Provision of services in the absence of/or insufficiency of interns and residents, and be it further

RESOLVED: That a report be given at the 1966 Annual Meeting.

THE REFERENCE COMMITTEE on Resolutions, H. M. Golden, M.D., Chairman, recommended disapproval of this resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 48

A Need for General Practitioners

Introduced by E. S. Woodworth, M.D., Livingston

Whereas, the need for family physicians is becoming more acute and demanding every year, especially in rural and semi-rural areas, and

Whereas, in spite of continued assurance by the medical schools of this state and the Michigan State Medical Society through its Council that means of correcting this problem are being studied, the supply of young physicians interested in general and/or rural medical practice continues to decline, and

Whereas, MSMS has had a standing committee to study this problem which, due to the complexity of the situation, has developed no apparent solution to the dilemma, therefore be it

RESOLVED: That The Council of the MSMS be urged to place on the agenda for their next meeting and give utmost precedence to a full scale hearing concerning the problem of interesting increased numbers of young physicians in general and rural medical practice in this state.

THE REFERENCE COMMITTEE on Resolutions, H. M. Golden, M.D., Chairman, recommended no action on this resolution because its intent is incorporated in Reference Committee amendments to Resolution 50.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 49

Establishment of an American International Medical Service Office

Introduced by James A. Ferguson, M.D., Kent

Whereas, many underdeveloped countries of the world are in need of medical assistance for the proper development of their potential, and

Whereas, many American physicians are being called upon to render this assistance through programs such as Project Vietnam, and

Whereas, the need for such help will greatly increase in demand and scope in the year to come, and

Whereas, the American Medical Association should be prepared for this trend and should lead it, therefore be it

RESOLVED: That the Michigan State Medical Society recommend to the American Medical Association that it set up an office, possibly called the American International Medical Service Office, and that this office act:

1. To promote the idea of international service,
2. To recruit physicians and auxiliary skilled people as volunteers.
3. To assist and help coordinate the activities of other agencies active in international health,
4. To assist in obtaining funds and equipment for international medical needs,
5. To demonstrate to the people of the United States and the world the great body of good will and humanitarian concern existing in the American medical group, and be it further

RESOLVED: That each state medical society be requested to similarly establish a sub-office or committee within their state.

THE REFERENCE COMMITTEE on Miscellaneous Business, V. V. BASS, M.D., Chairman, recommended approval of this Resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 50

Preceptorship in General Practice

Introduced by Fred C. Brace, M.D., Kent

Whereas, with the exception of several stimulated areas, the rank of the general practitioner have been depleting so rapidly that emergencies of communities desperate for medical aid exist all over this scientifically advanced and superior country of ours, and

Whereas, in our medical system it is imperative that the family doctor continue to be the backbone of American medicine because it is economically impossible to supply full-time specialist coverage for the thousands of towns and hamlets with population of 2,000 and less, and

Whereas, medical education has stressed specialization in its zeal for ultimate perfection (and this is as it should be) to the point where general practice is seldom mentioned in medical school, therefore be it

RESOLVED: That the Council of the Michigan State Medical Society appoint a committee consisting of key personnel from the Michigan Academy of General Practice, the University of Michigan Medical School, and the Wayne State University School of Medicine for the purpose of evaluating and setting up a preceptorship in family practice similar to the successful plans now operating in Kansas and Iowa.

THE REFERENCE COMMITTEE on Resolutions, H. M. Golden, M.D., Chairman, recommended approval of this resolution with the following amendment: Add to the end of the Resolved, "and to consider other methods for stimulating, interesting and training more young physicians in general and rural practice in this state."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 51

Commendation to MSMS Staff

Introduced by Harold F. Falls, M.D., Washtenaw

Whereas, the arrangements and preparations for this Centennial Session of the Michigan State Medical Society have been unavoidably momentous and taxing, and

Whereas, it is obvious that the Michigan State Medical Society executive staff and the office personnel have extended yeoman efforts in our behalf for at least two years, therefore be it

RESOLVED: That the House of Delegates acclaim these efforts with sincere thanks and appreciation for a job well done!

THE HOUSE suspended the rules and acted upon this item as a committee of the whole, adopting the resolution by standing vote.

RESOLUTION 52

Opposing The Classification of a Physician Service as a Hospital Service

Introduced by H. C. Tellman, M.D., Muskegon

Whereas, the implementation of the Douglas Amendment would tend to classify the services of certain specialties such as, anesthesiology, radiology, pathology, and physiatry as hospital services, be it

RESOLVED: That MSMS go on record as opposing the classification of certain specialists such as, anesthesiologists, pathologists, radiologists and physiatrists as true hospital employees, and be it further

RESOLVED: That MSMS oppose the classification and payment of their services as hospital services.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, recommended no action on this resolution since the intent of it had been accomplished in the House action on Resolution 33.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 53

MDPAC Annual Dues Billing

Introduced by V. V. Bass, M.D., Saginaw

Whereas, Resolution 26 of the 1964 MSMS House of Delegates endorsed, encouraged and strongly recommended that every Michigan doctor of medicine become a member of MDPAC and AMPAC, as independent, voluntary, nonprofit, bipartisan organizations to promote political education and political action, and

Whereas, Resolution 78 adopted by the House of Delegates of the American Medical Association in 1964 resolved: "That the House of Delegates of the American Medical Association does hereby commend those states that have established voluntary billing procedure; and be it further

RESOLVED: That this House of Delegates urge all states and component medical associations to approve, where possible, the inclusion of a voluntary, non-deductible contribution to independent political action committees on the society annual dues billing statement," and

Whereas, a number of state medical associations have already approved such annual dues billing, therefore be it

RESOLVED: That this House of Delegates request that The Council of the Michigan State Medical Society study the recommendations of the Amercan Medical Association and approve the inclusion of the voluntary, non-deductible contribution of the independent Michigan Doctor's Political Action Committee on the next annual dues billing statement.

THE REFERENCE COMMITTEE on Ways and Means, W. K. Locklin, M.D., Chairman, recommended approval of this resolution with the following substitute Resolved:

RESOLVED: That this House of Delegates request The Council of the Michigan State Medical Society, after favorable interpretation by legal and tax counsel, to approve and implement the inclusion of billing for the voluntary, nondeductible contribution to the independent Michigan Doctor's Political Action Committee with the next annual dues statement.

THE HOUSE amended the report of the Reference Committee by changing, in the first Whereas, the word "bipartisan" to the word "nonpartisan" and then adopted the report as amended.

RESOLUTION 54

Medical Economics

Introduced by Ralph H. Pino, M.D., Wayne

Whereas, on five separate occasions over the past three decades, through studies of the economics of the distribution of medical care by the Michigan State Medical Society and the application of these studies—Blue Shield as one example—Congress has moved to leave the distribution of clinical health care in the hands of the medical profession, and

Whereas, the propagation of some unverified economic information to the public and to some segments of the health professions in recent years has caused serious curtailment of the strength of our leadership, and

Whereas, we have at hand an economic exhibit of detailed and verified figures based on our experience, which should be in the hands of our overall leadership, and carefully analyzed, therefore be it

RESOLVED: That this House of Delegates of the Michigan State Medical Society ask for the privilege of presenting details of our verified economic records and experiences to our AMA headquarters to be of aid to our leaders at this critical time in their heavy responsibilities.

THE REFERENCE COMMITTEE on Legislation and Public Relations, R. M. Stow, M.D., Chairman, recommended approval of this resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 55 was withdrawn by the introducer.

RESOLUTION 56

Commendation to Officers and Staff for Centennial Arrangements

Introduced by D. N. Sweeny, Jr., M.D., Wayne

Whereas, it has been a unique privilege and pleasure for the Delegates to participate in this once-in-our-lifetime session of the Michigan State Medical Society, and

Whereas, this Centennial Session has culminated months of planning by the officers, The Council and the Centennial Committee of this Society, and

Whereas, the preparation and arrangements for this occasion have placed a monumental burden of work upon the executive staff; therefore be it

RESOLVED: That the House of Delegates compliment and commend the officers, The Council, the Centennial Committee and the executive staff for this successful session; and be it further

RESOLVED: That the House express its heartfelt appreciation by a standing vote of thanks.

THE HOUSE suspended the rules and acted upon the resolution as a committee of the whole. The resolution was adopted by a standing vote.

SPECIAL MEMBERSHIPS

THE REFERENCE COMMITTEE on Special Memberships, B. P. Brown, M.D., Chairman, recommended approval of the following special memberships submitted by the component medical societies:

Life Memberships

Berrien County—L. L. Harrison, M.D.

Chippewa-Mackinac County—Charles F. Thompson, M.D.; Benjamin T. Montgomery, M.D.

Ingham County—Maurice Richardson, M.D.; Anna E. Grey, M.D.; H. J. Prall, M.D.; Arthur W. Newitt, M.D.

Kalamazoo County—Homer H. Stryker, M.D.

Kent County—Arthur H. Mollman, M.D.; Athol B. Thompson, M.D.; J. Clinton Foshee, M.D.; Emery D. Winfield, M.D.; Ralph V. Allen, M.D.; Arthur M. Moll, M.D.; G. Howard Southwick, M.D.

Monroe County—Reginald W. McGeoch, M.D.

Newaygo County—Hugh R. Moore, M.D.

Oakland County—Donald J. Barnes, M.D.; Harold A. Furlong, M.D.; Daniel J. Hackett, M.D.; Colonel R. Henry, M.D.; Hayden D. Palmer, M.D.; Aaron D. Riker, M.D.

Sanilac County—Weldon A. Gift, M.D.

Tuscola County—Lloyd L. Savage, M.D.

Washtenaw County—Irene H. Sparling, M.D.; Fred J. Hodges, M.D.; Verne L. Van Duzen, M.D.

Wayne County—Myra Babcock, M.D.; Vincent S. Mancuso, M.D.; Kenneth C. MacPherson, M.D.; James O. Anderson, M.D.; Frances Brown, M.D.; James E. Cole, M.D.; Warren B. Cooksey, M.D.; Casimer A. Domzalski, M.D.; Crosby D. Eaton, M.D.; Stanley C. Fenton, M.D.; Nicholas Gigante, M.D.; Ralph E. Hall, M.D.; Clarence N. Jaekel, M.D.; Everett V. Johnston, M.D.; William E. Johnston, M.D.; Adrian R. Jones, M.D.; Herbert I. Kallet, M.D.; Edmund J. Knobloch, M.D.; Nathan Levitt, M.D.; John A. Maloney, M.D.; Alton R. Marsh, M.D.; James R. Marshall, M.D.; Myron H. Miller, M.D.; Harry M. Nelson, M.D.; John B. Nill, M.D.; Jerome Pawlowski, M.D.; Samuel H. Ruskin, M.D.; Edward L. Sager, M.D.; Stanley V. Sciarrino, M.D.; Charles W. Sellers, M.D.; Roger S. Siddall, M.D.; James M. Stanton, M.D.

Retired Memberships

Calhoun County—Stanley T. Lowe, M.D.

Ingham County—C. J. Stringer, M.D.; Robert J. Morrow, M.D.

Ionia-Montcalm County—Harold C. Mitchell, M.D.

Kalamazoo County—Don Vincent Estill, M.D.; Norman L. DeWitt, M.D.; Anthony P. Stiller, M.D.

Newaygo County—John William O'Neill, M.D.

Wayne County—Joseph C. Brisson, M.D.; Gordon K. Glasgow, M.D.; Ernest Newman, M.D.; Arthur J. Roberts, M.D.; Joseph Klosowski, M.D.

Associate Memberships

Ingham County—Richard U. Byerrum, Ph.D.; William H. Knisely, Ph.D.

Washtenaw County—Eugene M. Britt, Ph.D.; Alexander Barry, Ph.D.

The lists of candidates for Associate Membership from Washtenaw and Wayne Counties were reviewed. Since all candidates are doctors of medicine, no action was required by the House of Delegates, inasmuch as they may become Associate Members of this Society upon application and certification by the secretary of their component societies.

THE HOUSE adopted the report of the Reference Committee

PRESENTATIONS AND AWARDS

CERTIFICATES OF COMMENDATION

President McGillicuddy presented the following Certificates of Commendation as authorized by the House of Delegates:

Fred J. Hodges, M.D., Ann Arbor—

"In recognition of his distinguished career in radiology and in training doctors, especially during his thirty-four years with the University of Michigan, and also for his outstanding contributions to the Atomic Energy Commission of Michigan, the DuPage Project and the American Cancer Society."

Traian Leucutia, M.D., Detroit—

"In recognition of his distinguished career as a radiologist at Harper Hospital, as a Past President of the Michigan and National Roentgen Ray Societies, as editor of his specialty journal, and for his extensive research and paper on radiation therapy."

Remus J. Robinson, M.D., Detroit—

"In recognition of his fine service as a practicing physician and surgeon in Detroit for twenty-five years and as a distinguished public servant. He has served his community well as a member and President of the Detroit Board of Education and as a leader in many other civic efforts."

MICHIGAN'S OUTSTANDING PHYSICIAN

President McGillicuddy presented the following award, as authorized by the House of Delegates, to Franklin L. Troost, M.D., of Holt, as Michigan's Outstanding Physician of 1965:

"In recognition of your distinguished career in medicine and community service. As a physician, you have served on the State Board of Registration in Medicine, as the Holt School Team Physician for 34 years, as a delegate to the MSMS House of Delegates, and as an advisory board member of the local polio foundation. As a concerned citizen, you have served as a member of the Delhi Township Board, as chairman of the Delhi Township Zoning Board, and as a delegate to the county and state conventions of your political party."

PRESENTATION OF GAVELS TO PAST SPEAKERS OF THE HOUSE OF DELEGATES

Speaker James J. Lightbody, M.D., as a part of the Centennial observance, presented gavels suitably inscribed to each of the following Past Speakers of the House of Delegates:

Henry R. Carstens, M.D., 1928
Philip A. Riley, M.D., 1938-39
Oscar D. Stryker, M.D., 1940-41
John S. DeTar, M.D., 1947-49
Jackson E. Livesay, M.D., 1954-56
Kenneth H. Johnson, M.D., 1957-59

BUSINESS, INDUSTRY, COMMUNICATIONS AWARDS

The House of Delegates in official session recognized the vitally important role which has been played, is being played and will be played in the future by the business, industrial and communications organizations in our great State. The MSMS Awards Committee selected a company in each of the three categories to receive the symbolic award.

Resolution Honoring Business

Whereas, the thousands of firms which comprise the business community of Michigan merit the special thanks of the doctors of medicine of this State for their unfailing support of the medical profession in its effort to provide our people with the best health care, and

Whereas, the Michigan State Medical Society is now proudly reviewing a century of achievement, much of which was made possible by the personal and collective contributions of the businesses of Michigan and their Foundations; therefore be it

RESOLVED: That this Society hereby now publicly and officially expresses its thanks to Michigan business, and pledges its intent of continued cooperation with business in our common efforts in the future.

Award to S. S. Kresge Company (received by Mr. W. E. Sturges, Vice President in Charge of Personnel and Public Relations):

"The Michigan State Medical Society Centennial Award. Symbolic of the outstanding cooperation of the business establishments and foundations of Michigan, as exemplified by the S. S. Kresge Company, which by their corporate support and the understanding of their individual executives have greatly contributed to medical progress."

Resolution Honoring Industry

"Whereas, due in large measure to the skilled hands and minds which make Michigan industry great, medical miracles have been accomplished during the last century, and

"Whereas, the Michigan State Medical Society should rightfully acknowledge with deep appreciation the role played by industry as a partner in medical progress, as a longer and healthier life span has been achieved; therefore be it

"RESOLVED: That this Society hereby now publicly and officially express its thanks to Michigan industry and pledge its intent of continued cooperation with industry in our common efforts in the future."

Award to the Kellogg Company (received by Mr. E. M. Leaver, Senior Vice President):

"The Michigan State Medical Society Centennial Award. Symbolic of the vitally important role which Michigan industries have played in health, as exemplified by the Kellogg Company. By their application of imagination and technical skill they have created many of today's medical miracles."

Resolution Honoring Communications

"Whereas, the great health advances achieved by the science and art of medicine can only realize their maximum potential for good when they are accurately and rapidly disseminated, and

"Whereas, the communications industry has, in the public interest and to the great benefit of both physicians and their patients, devoted its talents, time and techniques to cooperation with the medical profession in improving the health care of the people; therefore, be it

"RESOLVED: That this Society hereby now publicly and officially express its thanks to the communications media of Michigan, and pledge its intent of continued cooperation in our common efforts in the future."

Award to Station WJBK and WJBK-TV, Detroit (received by Mr. Harry R. Lipson, Vice President and General Manager of Station WJBK):

The Michigan State Medical Society Centennial Award. Symbolic of the magnificent contributions of the communications industry, as exemplified by Station WJBK and Station WJBK-TV in rapidly and effectively disseminating vital health information for the benefit of the people of Michigan.

GUEST SPEAKERS

The following persons addressed the House of Delegates and mementoes were presented to them by Speaker James J. Lightbody, M.D.

R. D. Atkinson, M.D., Chairman of the General Council, Canadian Medical Association

Wesley W. Hall, M.D., Vice Chairman of the Board of Trustees, American Medical Association

Walter Judd, M.D., former Congressman from Minnesota

RECOGNITION OF COMPONENT MEDICAL SOCIETIES

By the action of the 1964 House of Delegates it was determined that the component medical societies of MSMS should be re-chartered with appropriate ceremonies as a part of the celebration of the 100th anniversary of MSMS. During the twelve months which comprise the Centennial Year, the actual re-chartering of component medical societies will be taking place throughout the state.

At this Session, however, the House of Delegates recognized the 55 component medical societies by presenting to a representative of each society a replica of that society's original charter. Doctor Wiley presented the award to each of the following component medical societies (application for charter was made on the date indicated):

Allegan County Medical Society—November 6, 1902

Alpena-Alcona-Presque Isle County Medical Society—February 16, 1903 (Alpena), March 4, 1906 (Presque Isle)
Barry County Medical Society—November 11, 1902
Bay-Arenac-Iosco County Medical Society—September 15, 1902
Berrien County Medical Society—September 16, 1902
Branch County Medical Society—September 23, 1902
Calhoun County Medical Society—August 8, 1902
Cass County Medical Society—December 20, 1902
Chippewa-Mackinac Medical Society—December 13, 1902
Clinton County Medical Society—January 2, 1903
Delta-Schoolcraft Medical Society—December 31, 1902 (Delta), June 1, 1903 (Schoolcraft)
Dickinson-Iron Counties Medical Society—May 30, 1903
Eaton County Medical Society—September 25, 1902
Genessee County Medical Society—November 11, 1902
Gogebic County Medical Society—March 26, 1903
Grand Traverse-Leelanau-Benzie Medical Society—October 23, 1902 (Grand Traverse), August 15, 1903 (Benzie)
Gratiot-Isabella-Clare Medical Society—November 14, 1902 (Gratiot), April 6, 1903 (Isabella)
Hillsdale County Medical Society—August 27, 1902
Houghton-Baraga-Keweenaw Medical Society—September 20, 1902
Huron County Medical Society—February 20, 1903
Ingham County Medical Society—January 6, 1903
Ionia-Montcalm Medical Society—October 17, 1902 (Ionia), October 6, 1902 (Montcalm)
Jackson County Medical Society—November 26, 1902
Kalamazoo Academy of Medicine—September 17, 1902 (Kalamazoo County Medical Society), February 17, 1906 (Kalamazoo Academy of Medicine)
Kent County Medical Society—March 6, 1903
Lapeer County Medical Society—November 8, 1902
Lenawee County Medical Society—March 23, 1903
Livingston County Medical Society—September 20, 1902
Luce County Medical Society—December 30, 1902
Macomb County Medical Society—February 26, 1903
Manistee County Medical Society—October 14, 1902
Marquette-Alger Medical Society—November 28, 1902
Mason County Medical Society—October 23, 1902
Mecosta-Osceola-Lake Medical Society—September 20, 1902 (Mecosta), December 5, 1902 (Osceola)
Menominee County Medical Society—April 8, 1903
Midland County Medical Society—January 17, 1903
Monroe County Medical Society—October 18, 1902
Muskegon County Medical Society—September 3, 1904
Newaygo County Medical Society—March 7, 1904
North Central Medical Society—September 30, 1902
Northern Michigan Medical Society—September 23, 1907 (Antrim), December 24, 1902 (Charlevoix), May 30, 1903 (Cheboygan), January 10, 1903 (Emmet)
Oakland County Medical Society—September 19, 1902
Oceana County Medical Society—September 23, 1902
Ontonagon County Medical Society—September 5, 1907
Ottawa County Medical Society—December 8, 1902
Saginaw County Medical Society—October 14, 1902
St. Clair County Medical Society—January 17, 1903
St. Joseph County Medical Society—December 2, 1902
Sanilac County Medical Society—November 1, 1902
Shiawassee County Medical Society—December 8, 1902
Tuscola County Medical Society—January 24, 1903
Van Buren County Medical Society—November 7, 1902
Washtenaw County Medical Society—January 17, 1903
Wayne County Medical Society—November 28, 1902
Wexford-Missaukee Medical Society—December 8, 1904, December 11, 1902 (Missaukee), September 15, 1902 (Wexford)

FIFTY YEAR AWARDS

At the request of Speaker Lightbody, Secretary D. Bruce Wiley, M.D., presented the Fifty Year Award to the following:

Robert Criswell, M.D., Bay County
C. E. DeMay, M.D., Jackson County
J. J. Drake, M.D., Wayne County
Robert H. Fraser, M.D., Calhoun County
A. C. Furstenberg, M.D., Washtenaw County
Robert Greenidge, M.D., Wayne County
William S. Jones, Sr., M.D., Menominee County
Harry E. Lee, M.D., Wayne County
D. J. Leithauser, M.D., Wayne County
William W. MacGregor, M.D., Wayne County
Max Silverman, M.D., Wayne County
George D. Sutton, M.D., Genesee County
Hugh A. Sullivan, M.D., Wayne County
J. M. Sutherland, M.D., Wayne County

Doctor Wiley read the following names of Fifty Year Awardees who were unable to be present:

Van D. Barnes, M.D., Wayne County
Edward T. H. Best, M.D., Wayne County
James G. Carr, M.D., Wayne County
Harold E. Clark, M.D., Wayne County
R. M. Cooley, M.D., Jackson County
Thomas H. Crews, M.D., Wayne County
Bertha W. Ellis, M.D., Ingham County
C. Ward Ellis, M.D., Ingham County
Charles T. Foo, M.D., Clinton County
John W. Hansen, M.D., Wayne County
Russell R. Huston, M.D., Grand Traverse County
Marie Keilin, M.D., Muskegon County
John J. Kurtz, M.D., Genesee County
Frank Pray, M.D., Jackson County
O. M. Randall, M.D., Ingham County
Elwood A. Sharp, M.D., Wayne County
Fred M. Slaughter, M.D., Wayne County
Stanley Stealy, M.D., Crawford County

EMPLOYEE AWARDS

Doctor McGillicuddy announced that by action of the House of Delegates in 1961 the employees of the headquarters staff of the Michigan State Medical Society were to receive awards for certain tenure of employment.

The following awards were presented by President McGillicuddy:

Morris A. Riley—5 years' service
E. Ray Scott—5 years' service

TRIBUTE TO DECEASED FORMER MEMBERS OF THE HOUSE OF DELEGATES

Secretary Wiley read the following names, and the members of the House arose and stood in silent tribute to their memory:

A. H. Jacoby, M.D.	Bay County
Russell L. Mustard, M.D.	Calhoun County
Frank E. Luton, M.D.	Clinton County
Albert H. Miller, M.D.	Delta-Schoolcraft County
Russell L. Finch, M.D.	Ingham County
Percival C. Strauss, M.D.	Ingham County
Jacob VanLoo, M.D.	Ionia-Montcalm County
Abel J. Baker, M.D.	Kent County
James S. Brotherhood, M.D.	Kent County
Leo J. Kenney, M.D.	Kent County
Louis J. Hirschman, M.D.	Wayne County
Ralph A. Johnson, M.D.	Wayne County
Jack Rom, M.D.	Wayne County
Clarence E. Umphrey, M.D.	Wayne County

ELECTIONS

The following Officers and Councilors were elected:

President-elect—C. Allen Payne, M.D., Grand Rapids
Speaker—James J. Lightbody, M.D., Detroit
Vice Speaker—Louis F. Hayes, M.D., Gaylord

Councilors (3-year terms)—

1st District: R. R. Cooper, M.D., Grosse Pointe (to fill unexpired term to 1967); M. R. Weed, M.D., Dearborn

5th District: J. R. Pedden, M.D. (to fill unexpired term to 1967)

7th District: J. R. Coury, M.D., Port Huron

8th District: A. C. Stander, M.D., Saginaw

10th District: E. H. Rodda, M.D., Bay City

12th District: E. R. Elzinga, M.D., Marquette

15th District: R. J. Mason, M.D., Birmingham

Delegates to the American Medical Association

(January 1, 1966-December 31, 1967)

Wm. A. Hyland, M.D., Grand Rapids
Luther R. Leader, M.D., Birmingham
Robert E. Rice, M.D., Greenville
John R. Heidenreich, M.D., Daggett

Alternate Delegates to the American Medical Association

(January 1, 1966-December 31, 1967)
(in order of seniority)

Wyman C. C. Cole, Sr., M.D., Detroit
Bradley M. Harris, M.D., Ypsilanti
Otto K. Engelke, M.D., Ann Arbor
Gilbert B. Saltonstall, M.D., Charlevoix

Alternate Delegate to the American Medical Association

(to fill vacancy for term expiring December 31, 1966)

Joseph A. Witter, M.D., Detroit (replacing Robert E. Rice, M.D., elected Delegate).

DIRECTORY

1965 MSMS House of Delegates

RECORD OF ATTENDANCE

	Meetings						
	1st	*2nd*	*3rd*	*4th*	*5th*	*6th*	*7th*
James D. Lightbody, M.D., Speaker, Detroit	X	X	X	X	X	X	X
Louis F. Hayes, M.D., Vice Speaker, Gaylord	X	X	X	X	X	X	X
D. Bruce Wiley, M.D., Secretary, Utica	X	X	X	X	X	X	X

MEMBER-AT-LARGE

	1st	2nd	3rd	4th	5th	6th	7th
Orlen J. Johnson, M.D., Immediate Past President, Bay City	X	X	X	X	X	X	X

DELEGATES

	1st	2nd	3rd	4th	5th	6th	7th
ALLEGAN							
Lewis E. Brown, M.D., Otsego	X	X	X	X	X	X	X
ALPENA-ALCONA-PRESQUE ISLE							
John W. Bunting, M.D., Alpena	X	X	X	X	X	X	X
BARRY							
Robert J. Huebner, M.D., Hastings	X	X	X	X	X	X	X
BAY-ARENAC-IOSCO							
William G. Gamble, M.D., Bay City	X	X	X	X	X	X	X
Robert C. Prophater, M.D., Bay City	X	X	X	X	X	X	X
BERRIEN							
Frederick H. Lindenfeld, M.D., Niles	X	X	X	X	X	X	—
Paul O. Rague, M.D., Benton Harbor	X	X	X	X	X	X	X
BRANCH							
Robert M. Leitch, M.D., Union City	X	X	X	X	X	X	X
CALHOUN							
George T. Kelleher, M.D., Battle Creek	X	X	X	X	X	X	X
Russell C. Rowan, M.D, Albion	X	X	X	X	X	X	X
Keith S. Wemmer, M.D., Battle Creek	X	X	X	X	X	X	X
CASS							
Sherman L. Loupee, M.D., Dowagiac	—	—	X	X	X	—	—
CHIPPEWA-MACKINAC							
Donald P. Finlayson, M.D., Sault Ste. Marie	X	X	X	X	X	X	X
CLINTON							
Franklin S. Smith, M.D., St. Johns	X	X	X	X	X	X	X
DELTA-SCHOOLCRAFT							
Raymond L. Hockstad, M.D., Escanaba	X	X	X	X	X	X	X
DICKINSON-IRON							
Donald T. Anderson, M.D., Kingsford	X	X	X	X	X	X	—
EATON							
Byron P. Brown, M.D., Charlotte	X	X	X	X	X	X	X
GENESEE							
Wm. F. Buchanan, M.D., Fenton	X	X	X	X	X	X	X
Clifford W. Colwell, M.D., Flint	X	X	X	X	X	X	X
H. Maxwell Golden, M.D., Flint	X	X	X	X	X	X	X
Ernest P. Griffin, Jr., M.D., Flint	X	X	X	X	X	X	X
Richard J. McMurray, M.D., Flint	X	X	X	X	X	X	X
Philip K. Stevens, M.D., Flint	X	X	X	X	X	X	X

	Meetings						
	1st	*2nd*	*3rd*	*4th*	*5th*	*6th*	*7th*
GOGEBIC							
John R. Franck, Jr., M.D., Wakefield	—	—	X	X	X	—	—
GRAND TRAVERSE-LEELANAU-BENZIE							
Frank H. Power, M.D., Traverse City	X	X	X	X	X	X	X
GRATIOT-ISABELLA-CLARE							
John M. Wood, M.D., Mt. Pleasant	X	X	X	X	X	X	X
HILLSDALE							
Arthur W. Strom, M.D., Hillsdale	X	X	X	X	X	X	X
HOUGHTON-BARAGA-KEWEENAW							
Andrew M. Roche, M.D., Calumet	—	X	X	X	X	—	—
HURON							
Charles W. Oakes, Jr., M.D., Harbor Beach	X	X	X	X	X	X	X
INGHAM							
Lawrence A. Drolett, M.D., Lansing	X	X	X	X	X	X	X
Herbert W. Harris, M.D., Lansing	X	X	X	X	X	X	X
D. Bonta Hiscoe, M.D., Lansing	X	X	X	X	X	X	X
Henry E. Malcolm, M.D., Lansing	X	X	X	X	X	X	X
Robert M. Stow, M.D., Lansing	X	X	X	X	X	X	X
IONIA-MONTCALM							
Robert E. Rice, M.D., Greenville	X	X	X	X	X	X	X
JACKSON							
Francis P. McQuillan, M.D., Jackson	—	—	X	X	X	X	X
Harold L. Oster, M.D., Jackson	X	X	X	X	X	X	X
KALAMAZOO							
William G. Birch, M.D., Kalamazoo	X	X	X	X	X	X	X
W. Kaye Locklin, M.D., Kalamazoo	X	X	X	X	X	X	X
Edwin O. Pearson, M.D., Kalamazoo	X	X	X	X	X	X	X
Frederick C. Ryan, M.D., Kalamazoo	X	X	X	X	X	X	X
KENT							
Harvey M. Andre, M.D., Grand Rapids	X	X	X	X	X	X	X
Noyes L. Avery, Jr., M.D., Grand Rapids	X	X	X	X	X	X	X
W. Clarence Beets, M.D., Grand Rapids	X	X	X	X	X	X	X
Fred C. Brace, M.D., Grand Rapids	X	X	X	X	X	X	X
James A. Ferguson, M.D., Grand Rapids	X	X	X	X	X	X	X
Frederick S. Gillett, M.D., Grand Rapids	X	X	X	X	X	X	X
John R. Pedden, M.D., Grand Rapids	X	X	X	X	X	X	X
Allison R. VandenBerg, M.D., Grand Rapids	X	X	X	X	X	—	X
LAPEER							
James R. Doty, M.D., Lapeer	X	X	X	X	X	X	X
LENAWEE							
Donato Sarapo, M.D., Adrian	X	X	X	X	X	X	X
LIVINGSTON							
Edwin S. Woodworth, M.D., Howell	X	X	X	X	X	X	X
LUCE							
Wm. A. Purmort, M.D., Newberry	X	X	X	X	X	X	X

	Meetings						
	1st	*2nd*	*3rd*	*4th*	*5th*	*6th*	*7th*
MACOMB							
Maurice S. Reizen, M.D., Huntington Woods	X	X	X	X	X	—	X
Sydney Scher, M.D., Mt. Clemens	X	X	X	—	X	X	X
Edward G. Siegfried, M.D., Mt. Clemens	X	X	—	X	X	X	—
MANISTEE							
Marlowe L. Schwarz, M.D., Onekama	X	X	X	X	X	X	X
MARQUETTE-ALGER							
Donald T. Conley, M.D., Marquette	X	X	X	X	X	—	—
MASON							
Herbert G. Bacon, Jr., M.D., Scottville	X	X	X	X	X	—	—
MECOSTA-OSCEOLA-LAKE							
Paul Ivkovich, M.D., Reed City	X	X	X	X	X	X	X
MENOMINEE							
Herman R. Brukardt, M.D., Menominee	—	X	—	—	X	X	X
MIDLAND							
Harold L. Gordon, M.D., Midland	X	X	X	X	X	X	X
MONROE							
S. Newton Kelso, Jr., M.D., Monroe	X	X	X	X	—	—	X
MUSKEGON							
Robert J. Fles, M.D., Muskegon	X	X	X	—	—	—	—
Leland E. Holly, II, M.D., Muskegon	X	X	X	X	X	X	X
H. Clay Tellman, M.D., Muskegon	X	X	X	X	X	—	X
NEWAYGO							
J. Paul Klein, M.D., Fremont	—	—	—	X	X	X	X
NORTH CENTRAL							
Charles L. Oppy, M.D., Roscommon	X	X	X	X	X	X	X
NORTHERN MICHIGAN							
Thomas R. Kirk, M.D., Petoskey	X	X	X	X	X	—	—
OAKLAND							
John L. Barrett, M.D., Birmingham	—	—	—	—	—	—	—
Carl H. Birkelo, M.D., Drayton Plains	X	X	X	X	X	X	—
Robert M. Bookmyer, M.D., Birmingham	X	X	X	X	X	X	—
Arnold L. Brown, M.D., Pontiac	X	X	X	X	X	—	X
Edward E. Elder, Jr., M.D., Pontiac	X	X	X	X	X	X	X
Richard R. Galpin, M.D., Birmingham	X	X	X	X	X	X	X
Paul T. Lahti, M.D., Royal Oak	X	X	X	X	X	X	X
John H. McLaughlin, M.D., Birmingham	X	X	—	X	X	X	X
James A. Read, M.D., Birmingham	X	X	X	X	X	X	X
F. Michael Sheridan, M.D., Royal Oak	X	X	X	X	X	X	X
OCEANA							
John J. Vrbanac, M.D., Hart	X	X	X	X	X	X	X
ONTONAGON							
James P. Strong, M.D., Ontonagon	—	—	X	X	—	X	—
OTTAWA							
John H. Kitchel, M.D., Grand Haven	—	—	—	—	—	—	—
SAGINAW							
Vernon V. Bass, M.D., Saginaw	X	X	X	X	X	X	X
Hugh T. Caumartin, M.D., Saginaw	X	X	X	X	X	X	X
Robert F. Powers, M.D., Saginaw	X	X	X	X	X	X	X
ST. CLAIR							
Anthony C. Gholz, M.D., Port Huron	X	X	X	X	—	—	—
Elmore D. Shoudy, M.D., Port Huron	—	—	—	—	X	—	—
James H. Tisdel, M.D., Port Huron	X	X	X	X	X	X	X
ST. JOSEPH							
Stanley C. Penzotti, M.D., Three Rivers	X	X	X	X	X	X	X
SANILAC							
Keate T. McGunegle, M.D., Sandusky	X	X	X	X	X	—	—
SHIAWASSEE							
Claude L. Weston, M.D., Owosso	X	X	X	X	X	X	X
TUSCOLA							
Edward J. Miles, M.D., Caro	X	X	X	—	X	X	X
VAN BUREN							
Edwin H. Terwilliger, M.D., South Haven	X	X	X	X	X	X	X
WASHTENAW							
Gerhard H. Bauer, M.D., Ann Arbor	X	X	X	X	X	—	X
Harold F. Falls, M.D., Ann Arbor	X	X	X	X	X	X	X
L. Dell Henry, M.D., Ann Arbor	X	X	X	X	X	X	X
John E. Magielski, M.D., Ann Arbor	X	X	X	X	X	X	X
Beverly C. Payne, M.D., Ann Arbor	X	X	X	X	X	X	X
Henry A. Scovill, M.D., Ypsilanti	X	X	X	X	X	X	X
Harry A. Towsley, M.D., Ann Arbor	—	—	X	X	X	X	X
C. John Tupper, M.D., Ann Arbor	X	X	X	X	X	X	X
WAYNE							
Seymour S. Adelson, M.D., Detroit	X	X	—	—	—	—	—
Sidney Adler, M.D., Detroit	X	X	X	X	X	—	—
Raphael Altman, M.D., Southfield	X	X	X	X	X	X	X
Raymond J. Barrett, M.D., Detroit	X	X	—	X	—	—	—
Elden C. Baumgarten, M.D., Grosse Pointe Woods	—	—	—	X	X	—	—
Frank B. Bicknell, M.D., Detroit	X	X	X	—	—	—	—
Alexander Blain, III, M.D., Detroit	X	X	X	X	X	X	X
James B. Blodgett, M.D., Detroit	X	X	X	X	X	X	X
Z. Stephen Bohn, M.D., Detroit	X	X	X	X	X	X	X
George T. Bradley, M.D., Detroit	X	X	—	X	X	X	X
William L. Brosius, M.D., Rochester	X	X	X	X	X	X	X
Brock E. Brush, M.D., Detroit	X	X	X	X	X	X	X
Louis Carbone, M.D., Detroit	X	X	X	X	X	X	X
Wyman C. C. Cole, Jr., M.D., Detroit	X	X	X	X	X	X	X
Paul J. Connolly, M.D., Detroit	X	X	X	X	X	X	X
James C. Danforth, Jr., M.D., Detroit	X	X	X	X	X	X	X
Charles E. Darling, M.D., Detroit	X	X	X	X	—	X	X
A. Jackson Day, M.D., Detroit	X	X	X	X	X	X	X
Herbert W. Devine, M.D., Detroit	X	X	X	X	X	—	X
Harold B. Fenech, M.D., Detroit	X	X	X	X	X	X	—
Russell F. Fenton, M.D., Detroit	X	X	X	X	X	X	X
George S. Fisher, M.D., Detroit	X	X	X	X	X	X	X
C. Jackson, France, M.D., Grosse Pointe	X	X	X	X	X	X	X
James D. Fryfogle, M.D., Southfield	X	—	X	X	X	X	—
Louis E. Heideman, M.D., Detroit	X	X	X	X	X	X	X
Homer A. Howes, M.D., Detroit	X	X	X	X	X	X	—
Eli J. Igna, M.D., Detroit	X	X	X	X	X	—	X
Benjamin Jeffries, M.D., Detroit	X	X	X	X	X	X	X
Conrad R. Lam, M.D., Farmington	X	X	X	X	—	X	—
John D. Langston, M.D., Detroit	—	—	—	—	X	—	—
Edward H. Lauppe, M.D., Detroit	X	X	X	X	X	X	X
Arthur B. Levant, M.D., Detroit	X	X	X	X	X	X	X
Max L. Lichter, M.D., Melvindale	X	X	X	X	—	X	X
E. Clarkson Long, M.D., Detroit	—	—	X	X	X	X	X
Edgar E. Martmer, M.D., Grosse Pointe	X	X	X	X	X	X	X
Clarke M. McColl, M.D., Detroit	X	X	X	X	X	X	X
G. Thomas McKean, M.D., Detroit	X	X	X	X	X	X	X
Marjorie Peebles-Myers, M.D., Detroit	X	X	X	X	X	X	—
George Mogill, M.D., Detroit	—	—	X	X	X	X	X
Joseph R. Montante, M.D., Detroit	X	X	X	X	X	—	—
John W. Moses, M.D., Detroit	X	X	X	X	X	X	X
Mario A. Petrini, M.D., Detroit	X	X	X	X	X	—	—
Ralph H. Pino, M.D., Plymouth	X	X	X	X	X	X	X
A. Hazen Price, M.D., Detroit	X	X	X	X	X	X	X
George L. Reno, M.D., Detroit	X	X	X	X	X	X	X
Francis P. Rhoades, M.D., Detroit	X	X	X	X	X	X	X
John G. Slevin, M.D., Grosse Pointe Park	X	X	X	X	X	X	X
Carl J. Sprunk, M.D., Melvindale	X	X	X	X	X	X	X
Ernest L. Stefani, M.D., Detroit	X	X	—	X	X	—	—
David I. Sugar, M.D., Detroit	X	X	X	X	X	—	—
Robert G. Swanson, M.D., Detroit	X	X	X	X	X	X	X
Donald N. Sweeny, Jr., M.D., Detroit	X	X	X	X	X	X	X
Milton R. Weed, M.D., Grosse Pte. Pk	X	X	X	X	X	X	X
Alfred H. Whittaker, M.D., Grosse Pte	X	X	X	X	—	—	—
Irvin A. Wilner, M.D., Detroit	—	—	X	X	X	X	X
Joseph A. Witter, M.D., Highland Park	X	X	X	X	X	X	X
William J. Yott, M.D., Detroit	X	X	X	X	—	X	X
WEXFORD-MISSAUKEE							
Dennis E. VanAlst, M.D., Cadillac	X	X	X	X	X	X	X
ANESTHESIOLOGY							
Ralph F. Askam, M.D., Muskegon	X	X	X	X	X	X	X
DERMATOLOGY							
Robert J. Schoenfeld, M.D., Birmingham	—	—	—	—	—	—	—
GASTROENTEROLOGY-PROCTOLOGY							
Joseph A. Rinaldo, Jr., M.D., Detroit	X	X	X	X	—	—	—
GENERAL PRACTICE							
Douglass A. Haddock, Jr., M.D., Kalamazoo	X	X	X	X	X	—	—
INTERNAL MEDICINE							
Clayton K. Stroup, M.D., Flint	X	X	X	X	X	—	—

	Meetings						
	1st	*2nd*	*3rd*	*4th*	*5th*	*6th*	*7th*
OBSTETRICS-GYNECOLOGY							
John W. Shriner, M.D., Midland	X	X	X	—	—	—	—
OCCUPATIONAL MEDICINE							
Harold J. Magnuson, M.D., Ann Arbor	X	X	X	X	X	X	X
OPHTHALMOLOGY							
James L. Frey, M.D., Detroit	—	—	—	—	—	—	—
OTOLARYNGOLOGY							
John E. Magielski, M.D., Ann Arbor	—	—	—	—	—	—	—
PATHOLOGY							
C. Allen Payne, M.D., Grand Rapids	X	X	X	X	X	—	—
PEDIATRICS							
Robert J. McGillicuddy, M.D., Lansing	X	X	X	X	X	—	X
PSYCHIATRY & NEUROLOGY							
Sanford M. Izner, M.D., Detroit	—	—	—	—	—	—	—
PUBLIC HEALTH & PREVENTIVE MEDICINE							
Oscar D. Stryker, M.D., Mt. Clemens	X	X	X	X	X	X	X
RADIOLOGY							
Benjamin R. VanZwalenburg, M.D., Grand Rapids	—	—	X	X	X	X	—
SURGERY							
John W. Derr, M.D., Detroit	—	—	—	—	—	—	—

	Meetings						
	1st	*2nd*	*3rd*	*4th*	*5th*	*6th*	*7th*
UROLOGY							
Robert C. Thumann, M.D., Grosse Pte. Woods	—	—	—	—	—	—	—
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John J. Coury, M.D., Port Huron	X	X	—	X	X	X	—
Robert V. Daugharty, M.D., Cadillac	X	X	X	X	X	X	X
Otto K. Engelke, M.D., Ann Arbor	X	X	X	X	X	X	—
Harvey C. Hansen, M.D., Battle Creek	—	—	X	X	X	X	X
Harold H. Hiscock, M.D., Flint	—	—	X	X	X	X	X
William A. Hyland, M.D., Grand Rapids	X	X	X	X	X	—	—
Kenneth H. Johnson, M.D., Lansing	X	X	X	X	X	X	X
Orlen J. Johnson, M.D., Bay City	X	X	X	X	X	X	—
William S. Jones, M.D., Menominee	X	X	X	X	X	—	—
L. R. Leader, M.D., Birmingham	X	X	—	—	—	—	—
Don Marshall, M.D., Kalamazoo	X	X	X	X	X	X	X
Robert J. Mason, M.D., Birmingham	X	X	X	X	X	—	—
Brooker L. Masters, M.D., Fremont	X	X	—	X	X	X	X
Edward H. Rodda, M.D., Bay City	X	X	X	X	X	—	—
D. Roemer Smith, M.D., Iron Mountain	X	X	X	X	X	X	—
George W. Slagle, M.D., Battle Creek	X	X	X	X	—	—	—
A. Carl Stander, M.D., Saginaw	X	X	X	X	X	X	X
Edward J. Tallant, M.D., Detroit	X	X	—	X	X	X	X
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Robert Buza, Detroit	—	—	—	—	X	—	—
Sara Kellerman, Ann Arbor	X	—	X	—	X	—	—
Theodore List, Ann Arbor	—	—	—	—	X	—	—
James Meeks, Detroit	—	—	X	X	—	—	—
Joel Nitzkin, Detroit	—	—	X	X	X	—	—
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